Single Technology Appraisal

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]

Committee Papers

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

SINGLE TECHNOLOGY APPRAISAL

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]

Contents:

The following documents are made available to stakeholders:

1. **Comments on the Draft Guidance from AbbVie**
   a. Company draft guidance response
   b. Company draft guidance response addendum*

2. **Consultee and commentator comments on the Draft Guidance** from:
   a. Ovacome (supporting report)
   b. Ovarian Cancer Action
   c. Target Ovarian Action

3. **Comments on the Draft Guidance from expert** – Prof Agnieszka Michael, nominated by British Gynaecological Cancer Society

4. **Comments on the Draft Guidance received through the NICE website**

5. **NICE and NDRS report including Systemic Anti-Cancer Therapy (SACT) data - updated**

6. **External Assessment Group critique of company comments on the Draft Guidance**
   a. EAG response to company's factual accuracy check*
   b. EAG critique of company's draft guidance response*
   c. EAG critique of company's draft guidance addendum*

7. **External Assessment Group documents following second committee meeting:**
   a. EAG – committee preferred assumptions and results following second committee meeting*
   b. EAG – updated results based on updated SACT report (5.)

Any information supplied to NICE which has been marked as confidential, has been redacted. All personal information has also been redacted.
**Please note the SACT report (5.) was updated after the second committee meeting. Results with updated SACT data are included in External Assessment Group document (7b.)*

NICE National Institute for Health and Care Excellence

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Draft guidance comments form

Consultation on the draft guidance document – deadline for comments 10am on 23 January 2026. Please submit via NICE Docs.

Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.

The Appraisal Committee is interested in receiving comments on the following:

- has all of the relevant evidence been taken into account?
- are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?
- are the provisional recommendations sound and a suitable basis for guidance to the NHS?

NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that the preliminary recommendations may need changing in order to meet these aims. In particular, please tell us if the preliminary recommendations:

- could have a different impact on people protected by the equality legislation than on the wider population, for example by making it more difficult in practice for a specific group to access the technology;
- could have any adverse impact on people with a particular disability or disabilities.

Please provide any relevant information or data you have regarding such impacts and how they could be avoided or reduced**.**

Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	AbbVie
Disclosure Please disclose any funding received from the company bringing the treatment to NICE for evaluation or from any of the comparator treatment companies in the last 12 months. [Relevant companies are listed in the appraisal stakeholder list.] Please state: • the name of the company • the amount • the purpose of funding including whether it related to a product mentioned in the stakeholder list • whether it is ongoing or has ceased.	Not applicable.
Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	Not applicable.
Name of commentator person completing form:	[redacted]

Comment number	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Overview	AbbVie is disappointed by the draft recommendation from the National Institute for Health and Care Excellence (NICE) not to recommend mirvetuximab for the treatment of folate receptor alpha (FRα)-positive platinum-resistant ovarian cancer (PROC). PROC is a severe and debilitating cancer impacting women, for which there have been no new treatments in the

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National Health Service (NHS) for over twenty years (paclitaxel, pegylated liposomal doxorubicin, and topotecan were first appraised by NICE in 2002 [TA45] and then again in 2005 [TA91]) (1, 2). Mirvetuximab is the first treatment to demonstrate a statistically significant and clinically meaningful overall survival (OS) benefit compared with single agent chemotherapy, addressing a critical unmet need in PROC. However, AbbVie appreciates the opportunity to comment on the draft guidance document (DGD) and to address the Committee's concerns.

Given AbbVie's aim of working collaboratively with NICE and NHS England (NHSE) to provide access to patients as soon as possible, [redacted] has been submitted.

Please note that there is also a [redacted], but this is expected to [redacted]. To date, [redacted] have received treatment with mirvetuximab. This early exposure has allowed for the process of testing and patient treatment to start to become integrated into the NHS ahead of mirvetuximab being recommended by NICE.
[redacted]

In response to the DGD, AbbVie has provided detailed comments on the key topics noted by the Committee as outlined below. These are separated into key issues with a high/medium impact on the incremental cost-effectiveness ratio (ICER), and other matters with low/uncertain impact on the ICER. An updated AbbVie base case and corresponding cost-effectiveness results are presented in Appendix 1, alongside key scenarios discussed throughout this document. AbbVie's revised base case has been updated to align with the Committee-preferred assumptions for: excluding the cost of topotecan, baseline age, frequency of gynaecology visits, crossover adjustment and removal of mirvetuximab as a post-progression therapy, inclusion of adverse event (AE) disutilities and excluding the cost of fatigue.

We would welcome further consideration of the conclusions from the first committee meeting. We are concerned that the input from clinical experts may not be fully reflected, particularly with respect to overall survival (OS), and that the assumptions regarding vial sharing are inconsistent with comparable appraisals and routine clinical practice. We also note that delays during the meeting curtailed clinical expert participation, which may have influenced the assumptions and conclusions.

Key topics with high/medium impact on ICER	DGD Section	Response
Overall Survival (OS) extrapolation for the mirvetuximab	3.9	The Committee concluded that there was uncertainty associated with both AbbVie's and the External Assessment Group's (EAG) approach.

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	and pooled chemotherapy arms		This response to the draft guidance provides evidence demonstrating that different extrapolation models are required for the mirvetuximab and pooled chemotherapy arms, and that the log-logistic and Weibull models are the most suitable choices for extrapolating OS beyond the trial period for mirvetuximab and pooled chemotherapy, respectively.
	Health Related Quality of life (HRQoL) of patients on chemotherapy	3.10	The Committee noted that the MIRASOL utility values suggested a small difference in HRQoL between patients receiving mirvetuximab and patients receiving chemotherapy. However, based on the patient and clinical expert feedback, the Committee considered that it was possible that the MIRASOL utilities did not fully capture the improvement in HRQoL offered by mirvetuximab compared with pooled chemotherapy. AbbVie welcomes the Committee's acknowledgement that it is possible the MIRASOL utilities did not fully capture the improvement in HRQoL offered by mirvetuximab. Furthermore, AbbVie accepts the limitations of using the Havrilesky et al (3) study for chemotherapy utilities. In order to appropriately reflect the expected differences in HRQoL between patients receiving mirvetuximab and chemotherapy, the company base case has been updated to reflect differences in utility before and after progression using data from the MIRASOL trial, and to account for the disutilities associated with adverse events, including alopecia.
	Severity modifier	3.17	The Committee noted that the three main factors influencing the absolute and proportional quality-adjusted life year (QALY) shortfall estimates are the average age of people starting treatment, the choice of utility values for the chemotherapy arm and the choice of OS extrapolation for pooled chemotherapy. AbbVie has demonstrated how PROC qualifies for the severity modifier of 1.7, when considering alternative sources of evidence for survival, as suggested by the Committee, whilst retaining the Committee's preferred assumptions on age and utilities for chemotherapy. The Committee also concluded that there is a high disease burden for people with ovarian cancer. Given the high unmet need, the lack of new treatment options in over 20 years, the poor efficacy and substantial toxicity of current treatment options for patients with PROC and potential equitable access issues that could be resolved by mirvetuximab, we invite the Committee to consider these broader factors in the application of the severity weighting for patient access.
	Vial sharing	3.13	The Cancer Drugs Fund (CDF) lead opinion during the committee meeting was that there was uncertainty regarding the feasibility of vial sharing given the anticipated population size. Based on the CDF lead's opinion, the Committee concluded that the model should not include vial sharing for mirvetuximab.

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			However as noted in the DGD, the CDF clinical lead present during the TA862 (second-line trastuzumab deruxtecan in breast cancer, Feb 2023) appraisal had said that NHSE encourages vial sharing and therefore 50% vial sharing could be assumed for trastuzumab deruxtecan. The same assumption would therefore be expected to apply to a therapy with broadly similar eligible patient population numbers, appraised within the following 3 years. For context, according to the NICE resource impact statement for TA862, 600 patients were expected to be eligible for second-line trastuzumab deruxtecan; this compares with approximately [redacted] eligible for mirvetuximab, as reflected in the submitted Budget Impact Analysis, which has been reviewed and accepted by NHSE. Feedback from NHS pharmacists and consultants that AbbVie consulted is that patients with PROC are frequently scheduled for treatment on specific days of the working week, therefore, the opportunity for substantial vial sharing is enhanced.
	Other topics with low/ uncertain impact on ICER	**DGD Section**	**Response**
	Relative Dose Intensity (RDI)	3.12	The Committee aligned with the EAG to apply a cycle-specific RDI over a single pooled estimate. AbbVie however notes that the RDI is broadly consistent over time and a cycle-specific RDI is determined by low patient numbers in later time periods.
	Adverse Events	3.11	The Committee concluded that the AE unit cost for neutropenia and anaemia should be costed using day case cost estimates, and fatigue would have zero cost as this would be self-managed. AbbVie aligns with the Committee that fatigue may be self-managed, however, additional costs would need to be considered for more severe cases of anaemia and neutropenia, not captured in day cases. Higher costs for these AEs align with previous ovarian cancer (OC) NICE TAs and the weighted average estimate used in AbbVie base case considers the distribution of severity in each setting.
	Mirvetuximab Duration of Treatment	3.15	The Committee preferred to estimate the duration of treatment for mirvetuximab using the Kaplan-Meier up to Week 120, followed by an exponential distribution. AbbVie were unclear how the 120-week time point had been chosen and preferred to apply the exponential distribution to the entire time to treatment discontinuation (TTD) curve.
	Subgroup Analysis	3.7	While the Committee suggested that mirvetuximab may be more clinically effective in people with a primary platinum-free interval of more than 6 months, the subgroup analyses in MIRASOL were exploratory only, unstratified, and not powered to be able to draw this conclusion. Furthermore, the subgroup analyses were variable, as based on the p-value for treatment effect, primary platinum-free interval was statistically significant

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			for OS but not for progression free survival (PFS). As such, the subgroup analyses should be interpreted with caution.
	Uncaptured benefits	3.20	AbbVie has highlighted additional benefits of mirvetuximab uncaptured by the economic model for consideration of the Committee in their decision making. These include the inequity in access to treatments for PROC and the resultant health inequalities, and how mirvetuximab aims to address these.

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1. OS extrapolation for the mirvetuximab and pooled chemotherapy arms	Section 3.9 of the DGD discusses the extrapolation of OS in the mirvetuximab and pooled chemotherapy arms, and the committee conclusion that there were uncertainties associated with both AbbVie's and the EAG's approaches. For mirvetuximab, the following reasons were outlined in the DGD in support of the Committee's chosen OS extrapolation, which was the gamma distribution: 1. There was not a strong justification for using different distributions in each arm 2. Decreasing hazards were not plausible given (a) patients' old age and (b) the visual fit towards the end of the observed hazards 3. The log logistic had a poor visual fit towards the end of the KM curve 4. Clinical expert opinion For pooled chemotherapy, the Committee selected the gamma distribution because it believed the same distribution should be used in each arm. This section provides further evidence which highlights the appropriateness of the log-logistic and Weibull distributions for mirvetuximab and pooled chemotherapy OS, respectively, including assessments of statistical and visual fit, hazard functions and the relationship with background mortality, clinical expert predictions of long-term survival and biological plausibility. **1. MIRVETUXIMAB AND POOLED CHEMOTHERAPY REQUIRE DIFFERENT EXTRAPOLATION MODELS** Section 3.9 of the DGD states that "there was not a strong justification for using different distributions in each arm". However, given that mirvetuximab and traditional systemic chemotherapy have substantially different mechanisms of action, and mirvetuximab significantly extends the duration of response and significantly reduces the tumour burden, there is no reason to believe that the functional forms of the hazards would be similar. This is also evident within the trial, where the observed hazards followed different trends; the hazard for mirvetuximab stabilised and only increased again once few patients were at risk, whereas the chemotherapy hazard shows a clear increasing trend (Figure 1). **Figure 1: Hazard plots for mirvetuximab (left) and pooled chemotherapy (right)**

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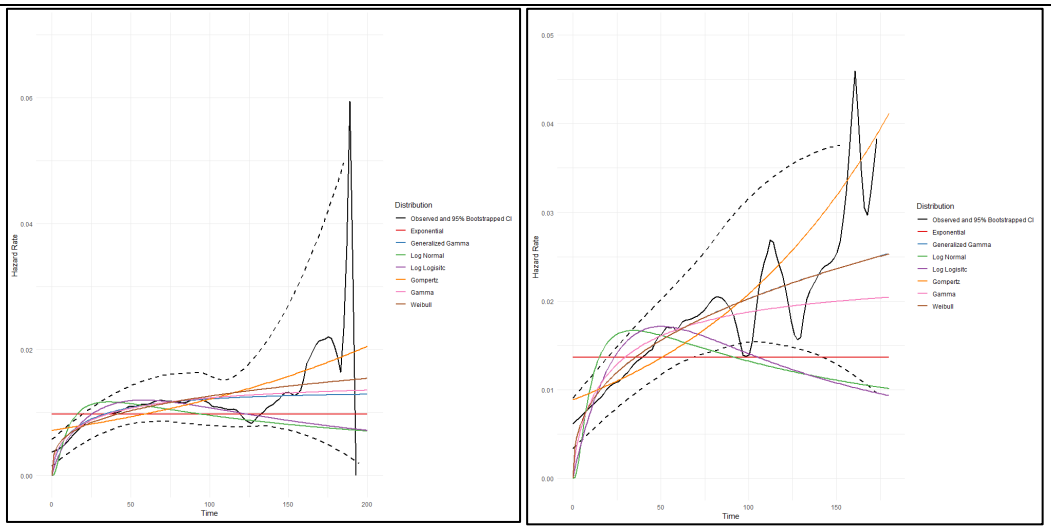

Clinical expert advice and biological plausibility based on the differing mechanisms of action between mirvetuximab and pooled chemotherapy support the use of different extrapolation models, in line with Technical Support Document 14 (4).

2. THE HAZARDS PREDICTED BY THE LOG-LOGISTIC DISTRIBUTION ARE THE MOST APPROPRIATE FOR EXTRAPOLATING THE OBSERVED HAZARDS

In Section 3.9 of the DGD, the Committee agreed with the EAG that the latter part of the Kaplan-Meier curve (after 24 months) should be interpreted with caution due to heavy censoring; however, the Committee also commented that "the log-logistic hazards appeared to be inconsistent with observed hazards because the observed hazard increased again after having initially increased then decreased."

It should be noted that the later increase in the hazard, on which the Committee based their choice of the gamma curve, is observed beyond 24 months (i.e. in the period in which the observed data is to be interpreted with caution). After this time point, the confidence intervals for the hazard become very wide due to low numbers at risk.

Figure 2 shows the observed hazard plot, with a black line marking the 24-month point, after which the EAG and the Committee agree that the data should be interpreted with caution. Based on the data observed prior to this time point, the log-logistic hazards follow the shape of the observed hazards consistently; notably, the smoothed hazard begins to decrease prior to 24 months, which aligns with the log-logistic, whereas the gamma curve continues to increase. The functional form of the gamma distribution only allows for a monotonically increasing or decreasing hazard, so it is not possible for the distribution to model the hazard once it decreases; in comparison, the log-logistic distribution can model a hazard which initially increases then decreases making it more suitable to model the shape of the smoothed hazard prior to it becoming unstable.

Figure 2: Observed hazard plot for mirvetuximab

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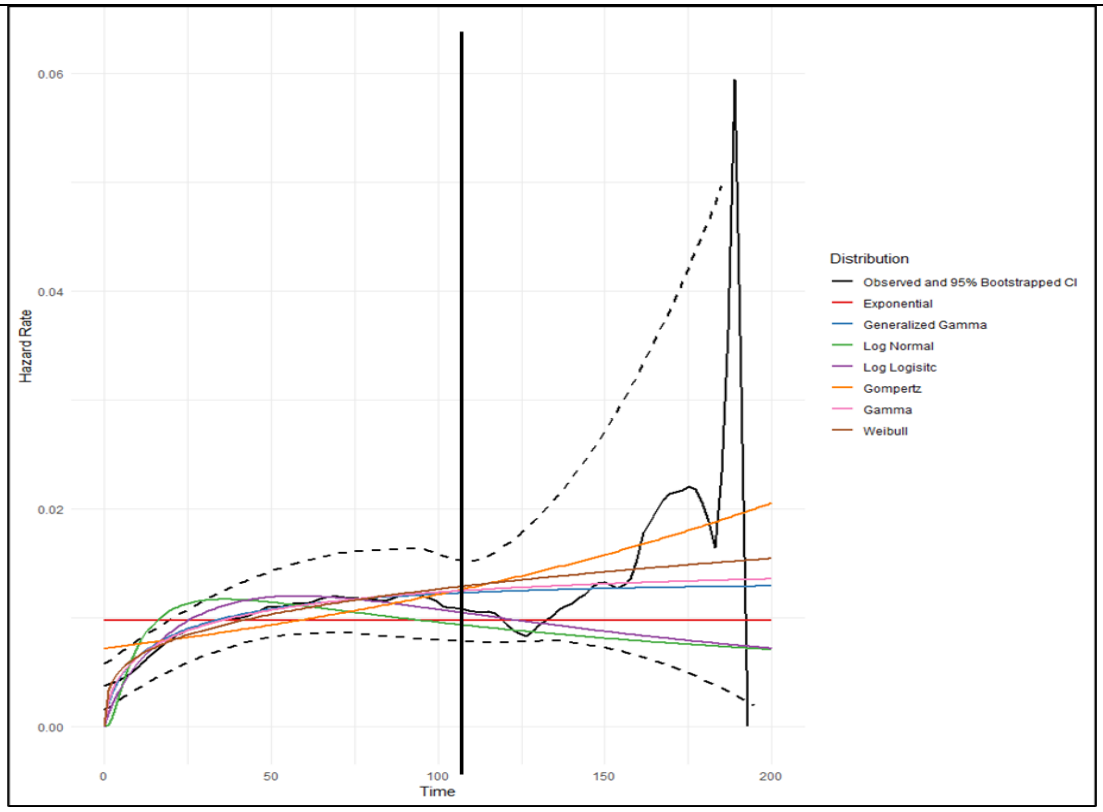

In addition, the DGD states that the Committee "thought that the hazard function implied by the log-logistic distribution (initially increasing then decreasing) was implausible in an older population. This was because the hazards would be expected to increase over time as more people die of old age."

Although the hazard of death does rise with age in the general population, this risk is considerably lower than the risk of mortality associated with PROC **(**Figure **3).** Within the time frame considered, it is therefore not expected that old age will necessarily lead to an increase in hazards.

Note that the model does include functionality for general population mortality to be applied where the modelled risk of death falls below that of the general population; in AbbVie's base case, this occurs at approximately 22 years, where less than 1% of the population remains alive.

Figure 3: Hazard of death over time

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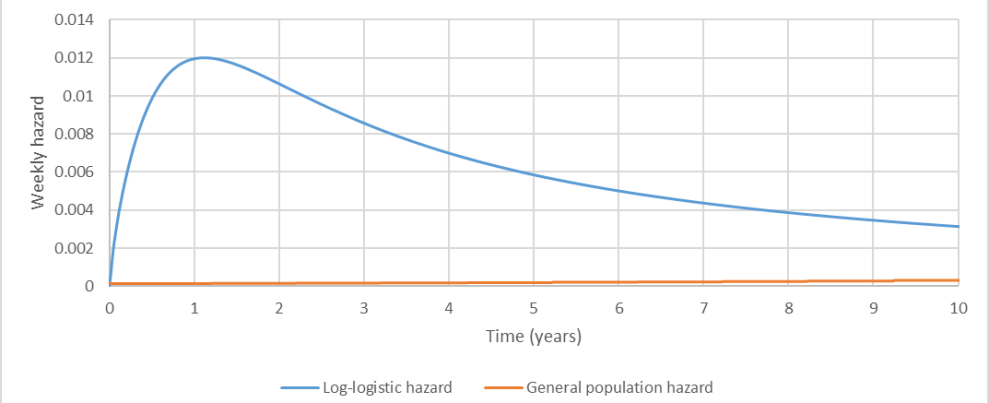


3. THE LOG-LOGISTIC PROVIDES A GOOD FIT TO THE OBSERVED KM DATA

In Section 3.9 of the DGD, the Committee commented that "the log-logistic distribution had a poor visual fit towards the end of the mirvetuximab Kaplan-Meier curve."

However, the Committee also stated that data after 24 months should be interpreted with caution due to heavy censoring. In the sections below, additional graphs have been presented to demonstrate that the log-logistic curve fits very closely to the observed data within (and even beyond) the first 24 months and only diverges from the observed data where the number at risk becomes very low and confidence intervals (CI) are wide.

Figure 4 shows the numbers at risk at each timepoint as well as where censoring occurred. A total of 64 patients in both arms were censored after month 24, 62 of whom were censored due to study closure, while 2 patients were censored for other reasons. Of the 62 patients who were censored due to study closure, 44 were in the mirvetuximab arm and 18 were in the pooled chemotherapy arm. These patients were alive during the last follow-up, and it is unknown how long they survived. Efforts were made by AbbVie to track the status of these censored patients, but this proved impossible.

Figure 4 :KM plot for OS – ITT population

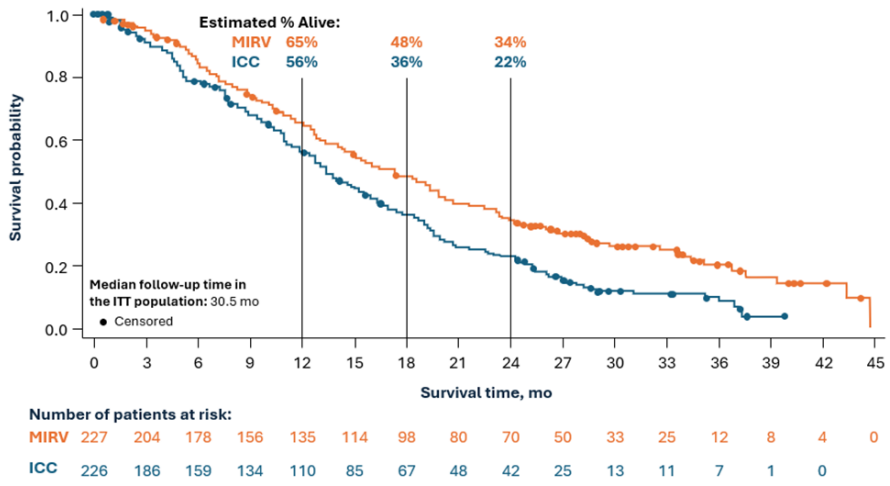
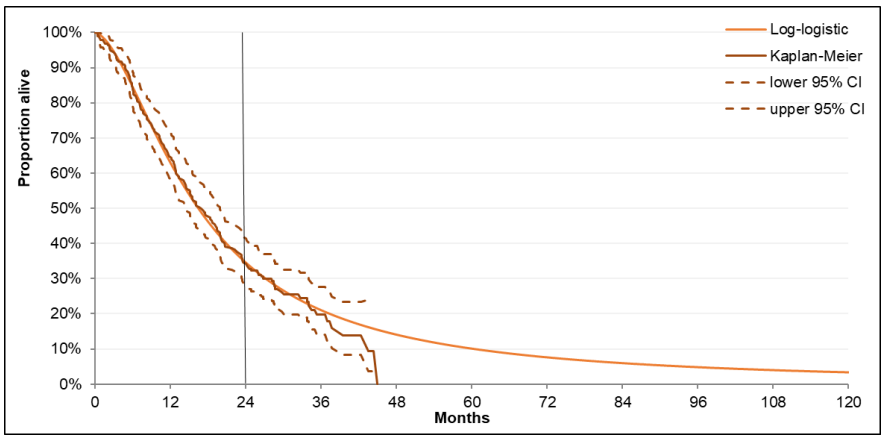


Figure 5 below shows the log-logistic extrapolation plotted alongside the mirvetuximab OS Kaplan-Meier (and corresponding 95% CI). A black line marks the 24-month point, after which the EAG and the Committee agree that the data should be interpreted with caution. AbbVie would like to highlight that up to 24 months, the log-logistic curve fits very closely to the observed data; after this point, the log-logistic curve falls relatively centrally within the 95% CI for the Kaplan-Meier (remaining close to the Kaplan-Meier up to approximately 36 months).

Figure 5: Log-logistic extrapolation and mirvetuximab overall survival Kaplan-Meier

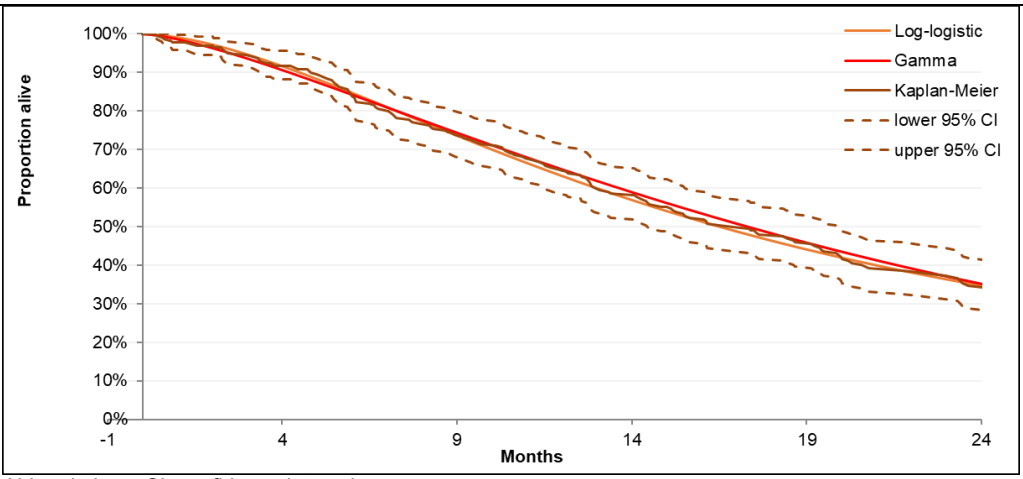


Abbreviations: CI, confidence interval

Figure 6 shows that up to 24 months, the visual fits of the log-logistic and gamma distributions are very similar. AbbVie had utilised a similar approach as a scenario in Appendix M of the company submission to identify the best-fitting distribution based on the most informative part of the data. This approach applied a more conservative cutoff at 147 weeks (~34 months), based on literature on the number at risk required for informative survival estimates.

Both cutoff points (24 months, corresponding to 18.5% of mirvetuximab patients at risk and ~34 months, corresponding to 10% of mirvetuximab patients at risk), reach the conclusion that both distributions have a good visual and statistical fit, with the log-logistic having a slight edge based on statistical fit (Appendix M).

Figure 6: Log-logistic and gamma extrapolations up to 24 months



Abbreviations: CI, confidence interval.

4. EXPERT PREDICTIONS AND MIRASOL TRIAL OUTCOMES SUPPORT THE LOG-LOGISTIC DISTRIBUTION FOR MIRVETUXIMAB

The previous three sections have established that (a) there is strong justification for using different distributions in each arm, (b) the hazards associated with the log-logistic are plausible, and (c) the visual fit at the end of the Kaplan-Meier curve cannot rule out the log-logistic distribution.

This section discusses the plausibility of each distribution based on data and clinical expert opinion.

Mirvetuximab

Per the DGD, at the committee meeting, clinical experts said that "it was plausible that about 10% could live beyond 5 years. This was because of mirvetuximab's novel mechanism of action."

The 5-year survival estimate with the log-logistic distribution is 10%. In contrast, the 5-year estimate with the gamma distribution is 4%, which is substantially lower than the experts' estimate during the committee meeting. These landmark estimates should also be considered together with the 3-year survival of 20% as observed in the MIRASOL trial. This was the final year of follow-up for which AbbVie has data.

It should also be noted that clinical experts have also highlighted the unprecedented OS results and the clear separation of survival curves and have consistently noted (a) the significantly improved response rates in the mirvetuximab arm and (b) significant progression free survival 2 (PFS2) data as additional clinical evidence of the long-term survival potential of mirvetuximab.

a) Objective response rate (ORR) is the proportion of patients achieving a complete or partial response from therapy. In the MIRASOL trial, the ORR for mirvetuximab (41.9%) was more than double that in the IC Chemo arm (15.9%; odds ratio [OR]: 3.75; 95% CI: 2.40, 5.85; p<0.0001). In the mirvetuximab group, 5.7% of patients achieved a complete response

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	(defined as all detectable signs of cancer having disappeared), compared with 0% of the IC Chemo patients. b) PFS2 is defined as the time from date of randomisation until second disease progression or death, whichever occurred first. The PFS2 data shows that the benefit of mirvetuximab vs IC Chemo was maintained beyond first progression. Mirvetuximab was associated with a statistically significant and clinically meaningful 41% reduction in the risk of second progression or death compared with IC Chemo (hazard ratio [HR]: 0.59; 11.01 vs 7.59 months, respectively; p<0.0001, difference in median PFS2 of 3.4 months). Considering the median PFS figures for mirvetuximab vs IC Chemo were 5.59 vs 3.98 months respectively (difference of 1.6 months), and that similar proportions of patients in each arm went on to receive a balanced selection of subsequent therapies, patients who received mirvetuximab continued to benefit during their next treatment(s). One potential reason for this result, as explained to AbbVie by clinical experts, is that mirvetuximab allows patients to have a break from standard cytotoxic chemotherapy and save a line of treatment for later (post mirvetuximab). Another reason could be that patients are fitter at the point of progression due to the improved response rates of mirvetuximab (5). Taken together, the MIRASOL trial outcomes and predictions from clinical experts invited to the first Committee meeting, all support the plausibility of the log-logistic 5-year survival rate, with the gamma 5-year survival rate being pessimistic. They also support the use of two different survival models for each treatment arm. *Pooled chemotherapy* The Committee's preferred distribution for pooled chemotherapy was the gamma. To AbbVie's understanding, this choice was made to align to the Committee's preferred distribution for the mirvetuximab arm. AbbVie believes that the use of different distributions in each arm is justified given the different mechanism of action and the distinctly different shape in the hazards. Therefore, the Weibull curve has been retained in the company base case because: • It provides the best fit to the smoothed hazard plot. The gamma distribution does not fit the shape of the hazard well, especially in the earlier part of the data. • The gamma distribution's landmark estimate of 1% at 5-years is optimistic in light of the 9-month median OS in clinical practice (Appendix 2). • The EAG noted that the Weibull distribution predicts 0% survival at 5-years. While this is accurate, AbbVie would like to point out that the precise estimate is 0.3% (compared to 0.8% with the gamma distribution), meaning that the Weibull also allows for a very small possibility of patients in the chemotherapy arm being alive at 5-years and beyond.
2. Health Related Quality of life (HRQoL) of patients on chemotherapy	AbbVie welcomes the Committee's acknowledgement that it is possible that the MIRASOL utilities did not fully capture the improvement in HRQoL offered by mirvetuximab compared with pooled chemotherapy. Furthermore, AbbVie accepts the limitations of using the Havrilesky et al (3) study for chemotherapy utilities, and instead has taken an updated approach in which utilities are modelled using an interaction term between treatment and progression. Disutilities associated with adverse events have also been applied as suggested by the Committee, with alopecia also included in line with clinician and patient group feedback regarding the substantial impact of this adverse event, even at lower grades.

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	POST-PROGRESSION UTILITIES ARE EXPECTED TO BE SUBSTANTIALLY DIFFERENT BETWEEN MIRVETUXIMAB AND POOLED CHEMOTHERAPY, AND ARE EXPECTED TO DIFFER BEFORE AND AFTER THE SECOND PROGRESSION AbbVie agrees with the Committee's observation that the improvement in HRQoL with mirvetuximab may be underestimated by the MIRASOL derived utilities. The difference between mirvetuximab and IC Chemo from the MIRASOL analysis, which was 0.03 in both the pre- and post-progression states implies a very minor difference in HRQoL between the two treatments. For example, the modelled disutility for neutropenia is 0.09 (i.e. three times the difference between patients receiving mirvetuximab and chemotherapy). This is considered inconsistent, given the stark difference in quality of life as reflected in the patient perspectives during the committee meeting, where it was emphasised that "people having mirvetuximab have a substantially better quality of life compared with people having chemotherapy". The EAG critique of the original company base case utility values stated that "the large difference in post-progression utilities between mirvetuximab (0.655) and pooled chemotherapy (0.400) was not supported by clinical logic. The EAG thought that the size of the difference was unlikely to be plausible because people would be expected to have similar subsequent treatments after progression in both arms." While AbbVie agrees that patients may be expected to have similar subsequent treatments between arms, as shown in the trial, the available evidence does not support an assumption of similar response to subsequent treatments between the two arms: • At the point of progression, reduced tumour volume and disease burden from mirvetuximab would likely translate to improved HRQoL burden; this benefit is expected to continue into the post-progression state. ○ The pronounced effect of disease burden reduction was demonstrated by the tumour shrinkage observed in >80% of patients treated with mirvetuximab (regardless of the line of treatment, including primary platinum resistance) compared with 55% of those treated with IC Chemo (6). Consequently, an ORR of 41.9% was achieved with mirvetuximab, more than double the rate achieved with IC Chemo (15.9%). Obtaining a complete tumour response in PROC is difficult to achieve and uncommon (7-11), however 13 (5.7%) mirvetuximab patients experienced a complete tumour response (vs 0% with IC Chemo) (12). • Mirvetuximab is associated with improved PFS2 compared with pooled chemotherapy (median 11.01 vs 7.59 months, respectively p<0.0001); patients therefore remain in the progression-free state at their next line of therapy for longer with mirvetuximab, translating into improved quality of life. AbbVie sought additional clinical expert opinion after the first committee meeting to ensure that QoL was being captured as accurately as possible. Clinical insights consistently suggested that given the PFS2 improvements and tumour response rates seen in MIRASOL, patients treated with mirvetuximab would be considered fitter at the point of progression, and as such have an improved chance of responding to their subsequent line, translating into improved quality of life. One reason for this is that mirvetuximab also affords the opportunity of saving a cytotoxic chemotherapy line to a later timepoint and thus patients would have less cross-resistance to cytotoxic chemotherapy than they would in the absence of mirvetuximab.

Expert opinion and literature estimates approximately a 15% chance that patients will respond to subsequent non-platinum chemotherapy (post mirvetuximab), which is the widely quoted response rate of traditional chemotherapy in PROC (13). This could be even higher given patients are going into their subsequent therapy having had a 'break' from systemic chemotherapy.

In contrast, in the case of standard of care chemotherapy, experts advised that it is extremely unlikely for any patients to respond to their second non-platinum therapy, and that these patients are out of options.

BASE CASE UTILITIES APPLY AN INTERACTION TERM BETWEEN TREATMENT AND PROGRESSION

To explore the impact of disease progression on patient utility values more comprehensively, interaction terms between progression status and treatment allocation were incorporated into the regression model. This approach uses utility data from the trial, and enables the analysis to move beyond simple additive effects, allowing us to test whether the effect of treatment on utility is consistent before and after progression.

Main effects for treatment allocation and progression status were included, together with an interaction term to determine whether the difference in treatment effect varied by progression state. In this case the inclusion of the interaction term quantifies how the utility benefit associated with mirvetuximab may change upon progression compared to chemotherapy, and allows for this to be incorporated in a robust manner.

The results demonstrated a notable interaction effect (Table 1). While mirvetuximab provided a modest utility advantage in the pre-progression state (utility: 0.732 vs 0.712), this advantage increased substantially after progression (utility: 0.675 vs 0.596). The interaction term quantified this 'cushioning' effect, demonstrating that mirvetuximab not only improved quality of life whilst progression free but also mitigated the detrimental impact of disease progression more effectively than chemotherapy.

In summary, the results of this analysis support the clinical understanding that mirvetuximab provides lasting benefits even as the disease progresses. The above approach to utilities provides a more robust and clinically meaningful representation of HRQoL across disease progression, and appropriately reflects the improvement in HRQoL with mirvetuximab as reported by patients.

Table 1: Base case utilities

	Committee chosen values	**Revised base case – interaction utilities**
Mirvetuximab: Pre-progression	0.737	0.732
Mirvetuximab: Post-progression	0.655	0.675
Pooled chemotherapy: Pre-progression	0.706	0.712
Pooled chemotherapy: Post-progression	0.625	0.596

Utilities using an interaction term had originally been presented in the company submission, however the EAG had noted that no goodness of fit statistics had been provided. As such, Appendix 3 provides the goodness of fit statistics, which demonstrates that the model fit is similar between the two models. Therefore, the choice of model should depend on face validity, and on which values best reflect the lived patient experience.

SCENARIO ANALYSIS: DIFFERENTIATING PFS2 UTILITIES

Based on insights around improved HRQoL in the line immediately following mirvetuximab, AbbVie has taken the approach to further differentiate within post-progression utilities in order to reflect this stark difference in quality of life between the first and second disease progression, depending on treatment arm. This approach has also been taken in TA992, and was accepted by the Committee (14).

For patients in the mirvetuximab arm, expert opinion suggests that the utility between the first and second progression would be equal to the pre-progression chemotherapy utility from MIRASOL. This is because these patients receive the same treatments (e.g. paclitaxel, pegylated liposomal doxorubicin) post progression, which are currently the only options in this patient population. This approach may be considered conservative, given that the median time from first progression to second progression in the mirvetuximab arm (5.42 months) is longer than the time to first progression in the chemotherapy arm (3.98 months).

After the second progression, it is assumed that the lower post-progression value from MIRASOL would apply; utility values used in the revised Company base case are presented in Table 3. The overall utility value in the progressed state for mirvetuximab (0.680) is calculated as a weighted average based on the proportion of time in the progressed state that is spent in PFS2 (Table 2).

Notably, this scenario produces utility values for mirvetuximab similar to those of the interaction term values (0.68 vs 0.675, Table 3).

Table 2: Data to inform the % of time in progressed state spent in PFS2 for mirvetuximab

Component	Value		Source
	Mirvetuximab	Pooled chemotherapy	
Median PFS	5.59	3.98	MIRASOL (15)
Median PFS2	11.01	7.59	MIRASOL (15)
Time between first and second progression	5.42	3.61	Calculated
Median OS	16.85	13.34	MIRASOL (15)
% of time in progressed state spent in PFS2	48%	39%	Calculated

Abbreviations: OS, overall survival, PFS, progression-free survival; PFS2, time to second disease progression or death.

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Table 3: PFS2 utility values (scenario)

Component	Value	
	Mirvetuximab	Pooled chemotherapy
Progression-free	0.737	0.706
Progressed		
Before second progression	0.706	0.625
After second progression	0.655	0.625
Weighted average	0.680	0.625

APPLICATION OF DISUTILITIES ASSOCIATED WITH ADVERSE EVENTS

Section 3.10 of the DGD states that the Committee preferred to include the disutilities associated with adverse events to capture the impact of side effects on HRQoL. AbbVie agree with the importance of reflecting the impact of adverse events, and has updated the Company base case model to include key adverse events including anaemia, keratopathy, blurred vision, cataract, neutropenia and thrombocytopenia.

Additionally, AbbVie has sought further insights from both clinical experts and patient groups to understand the impact of side effects on HRQoL. One adverse event that was consistently highlighted as a chemotherapy side effect with a substantial impact on patient QoL was alopecia. This is further echoed in the literature, where 47–58% of women report that alopecia is the most disturbing anticipated aspect of receiving chemotherapy (17, 18). The company base case has therefore been updated to also include this disutility, using the data presented in Table 4. The modelled disutility value (0.12) was consistent with the findings of Lloyd et al (19), who estimated a disutility of 0.114 associated with hair loss in metastatic breast cancer.

Table 4: Data used to model disutility for alopecia

Component	Value		Source
	Mirvetuximab	Pooled chemotherapy	
Proportion of patients experiencing alopecia	1%	14%	MIRASOL (15)
Duration of alopecia (weeks)	27.1	17.5	Assumed to last for the duration of primary treatment; median TTD values from MIRASOL converted to means assuming an exponential distribution.
Disutility	0.12		NICE TA958 (20) Calculated as the difference in utility between health states with 0-10% scalp hair loss (0.89) and 50-100% scalp hair loss (0.77).

Abbreviations: TTD, time to treatment discontinuation.

3. Severity	In Section 3.17 of the DGD, the Committee noted that the 3 main factors influencing the absolute and proportional QALY shortfall estimates are:

	1. The choice of OS extrapolation for pooled chemotherapy, 2. The choice of utility values for the pooled chemotherapy arm, and 3. The average age of people starting treatment. **THE SEVERITY MODIFIER CALCULATION SHOULD USE THE MEDIAN OVERALL SURVIVAL IN NHS CLINICAL PRACTICE WHICH IS LESS THAN 10 MONTHS** The Committee noted that it would be useful to have alternative data sources for pooled chemotherapy. AbbVie therefore consulted multiple NHS clinical experts to gain a better understanding of median OS durations of chemotherapy in real world PROC practice; 10–12 months was suggested. Notably, this is lower than the median OS of patients on chemotherapy in the MIRASOL trial (13.34 months). In addition, a retrospective analysis has been conducted by the Nicola Murray Centre for Ovarian Cancer Research, characterising the real-world outcomes of a cohort of patients with PROC treated at the Edinburgh Cancer Centre (21). A total of 301 patients met the inclusion criteria for the study (total PROC cohort), with 228 of these patients receiving treatment following a platinum-resistant relapse (treated PROC cohort). The median OS in the sub-population considered most comparable to the IC Chemo arm of MIRASOL (i.e. those who did not receive bevacizumab for PROC) was 9 months. Further details are provided in Appendix 2. Goal Seek functionality in Excel was used to identify the hazard ratio that could be applied to the OS curve for pooled chemotherapy such that the modelled median OS would be 9 months; this hazard ratio was found to be 1.71. A scenario analysis was therefore conducted in which the hazard ratio of 1.71 is applied to the modelled OS and PFS curves for pooled chemotherapy, to determine the severity modifier that would be expected to apply in clinical practice. Results of this scenario show that a severity modifier of 1.7 is expected to apply when OS data for IC Chemo is aligned with UK clinical practice. **THE UTILITY VALUES IN MIRASOL DO NOT FULLY CAPTURE THE POOR QUALITY OF LIFE OF PATIENTS ON CHEMOTHERAPY OR THE EXTENUATING FACTORS, PARTICULARLY IN RARE CONDITIONS.** **Disease Severity** PROC, the most underserved population of OC, is unique amongst cancers affecting women; it is rare, severe and incurable with low survival outcomes and there have been no new treatments in 20 years. It is a highly severe disease with distressing symptoms in the gastrointestinal system (nausea, vomiting, abdominal pain, bloating, recurrent ascites, constipation in some, diarrhoea in others, bowel obstruction), respiratory system (shortness of breath from pleural effusions), and general fatigue. The committee also concluded that there is a high disease burden for people with ovarian cancer. Both the patient group submissions to NICE and evidence provided at the committee meeting highlight the chemotherapy treatment related AEs and the very poor HRQoL. Of note is that these cumulative chemotherapy-related AEs can have such a negative impact on HRQoL that some patients with advanced OC choose to avoid treatment and trade meaningful progression-free survival (PFS) time in order to avoid severe AEs, highlighting the substantial treatment

	burden of this disease (3). Treatment options such as paclitaxel also increase disease burden due to the additional time needed to attend more frequent treatment administrations. **Available utility values do not fully capture the difference between mirvetuximab and pooled chemotherapy** Section 2 of this response to the DGD provides utility values that differ before and after the second progression, and best reflect the difference in utility between mirvetuximab and pooled chemotherapy in the absence of other data. However, the calculation of the severity modifier is impacted by the scarcity of available data in this rare condition, and the inability to fully capture the differences in quality of life that are evident through patient insights, both collected by AbbVie and discussed at the first committee meeting. As such, the poor quality of life experienced by patients on chemotherapy should be reflected in the utility used to calculate the severity modifier. **THE EAG ASSUMPTIONS ESTIMATE A PROPORTIONAL QALY SHORTFALL OF 0.93 WHICH IS VERY CLOSE TO THE THRESHOLD OF 0.95 FOR TRIGGERING THE 1.7 MODIFIER** AbbVie has demonstrated that PROC qualifies for the 1.7 severity modifier, when aligning with real-world estimates of OS for chemotherapy. However, it should be further noted that even with the EAG assumptions prior to the first Appraisal Committee Meeting (ACM), the proportional QALY shortfall of 0.93 is very close to 0.95, the weighting to trigger the 1.7 modifier. The Committee have also noted that there is a high disease burden for patients with ovarian cancer. Given the high unmet need (and impact on caregiver quality of life as described in Section 5) the lack of new treatment options in over 20 years and potential equitable access issues (Section 5) that could be resolved by mirvetuximab, AbbVie invites the Committee to consider these broader factors in the application of the severity weighting for patient access.
4. Vial Sharing	In the DGD, the Committee concluded that the model should not include vial sharing for mirvetuximab. The main rationale for this was based on the opinion of the CDF lead, and related to uncertainty regarding the plausibility of vial sharing for mirvetuximab due to the anticipated population size. In order to address these uncertainties, AbbVie has consulted 7 pharmacists working in major NHS trusts in England, including Chief pharmacists and specialist aseptic pharmacists who routinely undertake preparation of injectable cancer medicines in sterile units. Based on the additional insights gathered, we demonstrate that vial sharing should at least be consistent with the Committees preferred assumption for trastuzumab deruxtecan in TA862. **THE MIRVETUXIMAB PATIENT NUMBERS SUPPORT VIAL SHARING** As noted in our company submission, in the TA862 (trastuzumab, breast cancer, Feb 2023) appraisal, 50% vial sharing was accepted for trastuzumab deruxtecan. During the mirvetuximab Committee meeting, the CDF Lead said that vial sharing for mirvetuximab was unlikely to be feasible because the anticipated population for mirvetuximab is substantially lower than for trastuzumab deruxtecan.

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	According to the NICE resource impact statement for TA862, 600 patients are expected to be eligible for trastuzumab deruxtecan annually. This compares with approximately [redacted] eligible for mirvetuximab by Year 5, as reflected in the Budget Impact Analysis submission, which NHSE has reviewed and accepted. These patient numbers are broadly similar to those seen with trastuzumab deruxtecan, where the assumption of 50% vial sharing was considered acceptable. The additional information provided supports AbbVie's view that the assumption of 0% vial sharing is overly pessimistic given that patient numbers are expected to be similar to those of trastuzumab deruxtecan, for which 50% vial sharing has been previously accepted by the NICE Committee to apply. Additionally, Appendix 4 details how vial sharing is not only encouraged but operationally feasible for mirvetuximab due to the following reasons: : • How the clinical pathway supports vial sharing: Seven NHS gynaecological oncology pharmacists report that vial sharing for PROC, including mirvetuximab, can be achieved through clinic scheduling and coordination with aseptic pharmacies in centralised high volume centres, where aligning ovarian cancer patients on designated days enables same day preparation and practical vial sharing even with just two patients, without delaying treatment. • NHSE's stance on vial sharing: The NHS encourages vial sharing, especially for high-cost cancer medicines such as trastuzumab deruxtecan and mirvetuximab, if reimbursed. This is to reduce costs and medicine waste from single-use vials, improve inventory management and mitigate shortages through batching, and is supported by NHS England incentives and gainshare schemes (51). • The process for aseptic preparation: Because aseptic preparation of cancer medicines is a laborious, SOP- and QAAPS-governed process designed to prevent contamination and ensure patient safety, NHS gynaecological oncology pharmacists report that batching and vial sharing can be achieved via coordinated clinic scheduling with aseptic pharmacies, aligning ovarian cancer patients on specific days for same-day preparation; an approach expected to be feasible for PROC patients receiving mirvetuximab (52). As such, it is reasonable to assume 50% vial sharing will occur.
5. Benefits not captured	As noted in Section 3.19 of the DGD, the Committee considers health benefits that are uncaptured by the economic model. This section highlights several benefits of mirvetuximab to be qualitatively valued in Committee decision-making: 1. The rarity of PROC and lack of innovation 2. Care giver burden 3. Inequality in PROC treatment pathways.

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	RARITY OF PROC AND LACK OF INNOVATION As noted in the company submission, improving outcomes for rare and less common cancers was identified as a key area of focus in the recent Government National Cancer Plan consultation document (22). PROC, which includes fallopian tube and primary peritoneal cancer, is a type of rare cancer (23-25). Notably, the U.S. Food & Drug Administration (FDA) and European Medicines Agency (EMA) have both granted mirvetuximab orphan designation, which reflects not only the rarity but also the life threatening nature of PROC (23, 26). Rare diseases present a challenge for reimbursement, as key benefits to patients are not captured in economic modelling. As highlighted in the company submission, the value of hope for a new treatment as expressed by patients in an area that has seen no new treatment for decades, is an important consideration that cannot be quantified as part of the QALY, and has been discussed in the literature (27, 28). Mirvetuximab offers a novel treatment option in the PROC setting which has not seen a new treatment in over two decades, underscoring the importance of innovative treatments especially for patients with rare cancers facing limited treatment options. Unlike existing chemotherapies, mirvetuximab introduces a biomarker-selected approach, representing a step change from non-targeted chemotherapy to precision guided therapy. These benefits should be considered qualitatively when interpreting the overall value of mirvetuximab to patients and the NHS. **CAREGIVER QUALITY OF LIFE** Given that care giver burden is not reflected in the economic model, it is important to highlight the impact that the treatment and management of patients with PROC has on carers of patients (29). In one study, 55% of caregivers reported feeling moderately or extremely anxious or depressed (30). Additionally, treatment and management of patients with PROC are associated with considerable patient and caregiver time for travelling to or receiving treatment, with a corresponding reduction in productivity for patients and carers of a working age (31-36). The Adelphi real-world evidence (RWE) study commissioned by AbbVie in five countries, including the UK, found that caregivers for patients with PROC spend an average of 35.4 hours per week providing care, with partners/spouses spending 26.0 hours per week and children over 18 years spending 24.1 hours per week (37). As mirvetuximab is associated with a favourable safety profile compared with chemotherapy, it is reasonable to therefore assume that the burden on carers of patients treated with mirvetuximab would be lower than those treated with chemotherapy. Caregiver burden is not reflected within the economic model or the calculation of the severity modifier and therefore warrants further consideration. **CURRENT INEQUALITY IN PROC TREATMENT PATHWAYS** As noted in the company submission, AbbVie considers there to be various health inequalities within PROC. Further to the issues raised in the company submission, documented evidence shows access to, and benefit from chemotherapy may be unequal across patient groups in ovarian cancer (38-41). These inequalities arise as many chemotherapy schedules have a high burden on patients: • Complex AE management, requiring early reporting • Multiple hospital visits for supportive care

	• Greater likelihood of missed or delayed doses because of transport challenges (costs/far from centre), patients being unable to avoid time off work or able to organise childcare, as well as health literacy barriers. **HOW MIRVETUXIMAB ADDRESSES THESE ISSUES** Mirvetuximab introduces a treatment option which may help to address these inequalities. Importantly, mirvetuximab also has a safety profile that is more manageable compared with chemotherapy. Chemotherapy-related AEs have such a negative impact on HRQoL that patients with advanced OC are willing to trade meaningful survival in order to avoid severe AEs, highlighting the substantial treatment burden of this disease (3). By providing a treatment option with a more favourable safety profile, mirvetuximab would help to facilitate access to treatment for these patients who would otherwise choose to remain untreated. Furthermore, evidence shows that patients from ethnic minority backgrounds face more difficulties navigating support services (40, 41). For example, in a qualitative study exploring the experiences of cancer patients from ethnic minority backgrounds in England, a number of participants confirmed that poor experience can be associated with the language barriers experienced by older cancer patients from ethnic minority backgrounds (41). Language barriers, as well as previous poor experiences within healthcare systems, reduce the likelihood of raising issues or receiving help (40, 41). AbbVie therefore suggests that chemotherapy-related AEs may be more likely to impact these patients. Additionally, any treatment that requires time off work or additional childcare, such as to deal with AEs or for administration, may also disproportionally affect patients from ethnic minority backgrounds, as research has shown that the financial impact of a cancer diagnosis may be starker in people from ethnic minority backgrounds as some experience higher rates of poverty (41). This is further noted by Pickwell-Smith et al (2025), who suggested patients from more deprived backgrounds may face financial constraints, work commitments and caregiving duties that lead to reduced treatment uptake, particularly where the benefits of potentially toxic treatments are marginal (38). As mirvetuximab requires fewer visits than paclitaxel, and offers a less toxic profile than chemotherapies, mirvetuximab may reduce the need for these patients to seek additional help or deal with AEs for long periods. Finally, there are inequalities related to race and/or ethnicity regarding diagnosis. South Asian women and women from Caribbean and African backgrounds have been found to be more likely to be diagnosed with breast or ovarian cancer at a later stage, when treatment is less likely to be effective, therefore resulting in lower survival (42). A recent SLR suggests that this may also be the case for older and more socioeconomically deprived women with OC, who are more likely to be a diagnosed at a later stage following an emergency presentation (43). A new treatment such as mirvetuximab in the advanced disease state may therefore disproportionately benefit these women, particularly in the context of earlier identification via FR-alpha testing.
6. Mirvetuximab Duration of Treatment	Section 3.15 of the DGD discusses the Committee's preference to use the EAG approach for estimating mirvetuximab duration of treatment. The Committee-preferred assumption is to use the Kaplan-Meier for mirvetuximab up to Week 120, followed by the exponential distribution for modelling mirvetuximab duration of treatment. It is unclear how the specific time point of 120 weeks was selected. To avoid the selection of an arbitrary timepoint, AbbVie prefers to fit a parametric model to the entire DoT data for mirvetuximab. The exponential distribution provides the best statistical fit and has been validated by three UK clinical experts at an advisory board. It should also be noted that using

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<table>
<tr><td></td><td>Kaplan-Meier data for duration of treatment risks overinterpreting small variations within the trial which may not be reflected in the real world.

AbbVie therefore maintains that fitting the exponential to the entire dataset is the most appropriate approach. If the Committee believes that the Kaplan-Meier should be used, it would be more appropriate to use the entire Kaplan-Meier directly for all comparators, in the same way this has been applied to the three chemotherapy options.</td></tr>
<tr><td>7. Adverse Events</td><td>Section 3.11 of the DGD discusses the Committee's preference to assume that anaemia and neutropenia are managed as a day case and that fatigue is self-managed.

Although it is expected to be less common for patients with anaemia and neutropenia to require an overnight stay, these additional costs will be required in a proportion of patients with severe cases. The weighted average approach taken by AbbVie using the NHS reference costs appropriately accounted for these cases. As such, the current Committee-preferred base case therefore represents an underestimation of the AE costs.

AbbVie's base case is also consistent with previous NICE appraisals (TA1007, TA962, and TA946), as presented in Table 5. All OC technology assessments presented in Table 5 have higher anaemia and neutropenia unit costs compared with the Committee-preferred base case. AbbVie's base case aligned closely to the most recent previous NICE TA (TA1007), as the relevant NHS reference codes and settings were used in this appraisal. No changes to anaemia or neutropenia costs have therefore been made in the revised AbbVie base case.

Table 5: AE costs from previous OC submissions
<table>
<tr><th>AE</th><th>TA1007 (44)</th><th>TA962 (45)</th><th>TA946 (46)</th><th>Updated AbbVie base case</th><th>Committee -preferred base case</th></tr>
<tr><td>Anaemia</td><td>£930.62</td><td>£2,015.26</td><td>£876.87</td><td>£1,032.51</td><td>£391.68</td></tr>
<tr><td>Neutropenia</td><td>£1,458.66</td><td>£626.50</td><td>£667.35</td><td>£1,921.57</td><td>£399.36</td></tr>
</table>
Abbreviations: AE, adverse event; OC, ovarian cancer; TA, technology assessment.</td></tr>
<tr><td>8. Relative Dose Intensity</td><td>The Committee-preferred assumption (Section 3.12) aligned with the EAG's approach to apply cycle-specific RDI data, rather than a single pooled estimate. AbbVie notes that the EAG's approach to RDI originated from the EAG's expectation that patients who tolerate the full dose of mirvetuximab would remain on treatment for longer, and the concern that AbbVie's approach to RDI was underestimating the cost of treatment.

AbbVie has conducted additional analyses to further explore this, and the results demonstrate this not to be the case; as seen in Figure 7Figure 7, there is a clear trend that average RDI for mirvetuximab is broadly consistent over time.

Additionally, although the EAG's approach allows for the incorporation of time trends in both missed doses and dose changes, the RDI at later time points is determined by very low numbers of patients. As seen in Figure 7Figure 7, between cycle 10 and 20 the average number of patients drops below 50. As such, the cycle-specific RDI approach may be distorted by cycle-specific values in which data are available for very few patients, which could mean that a cycle-specific RDI approach would not necessarily provide more accuracy as originally concluded by the Committee.</td></tr>
</table>

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	AbbVie would therefore consider that a single estimate of RDI based on all available data results is the most reliable estimate of cost-effectiveness, and the additional analyses provide the Committee with the reassurance that AbbVie's approach is appropriate.

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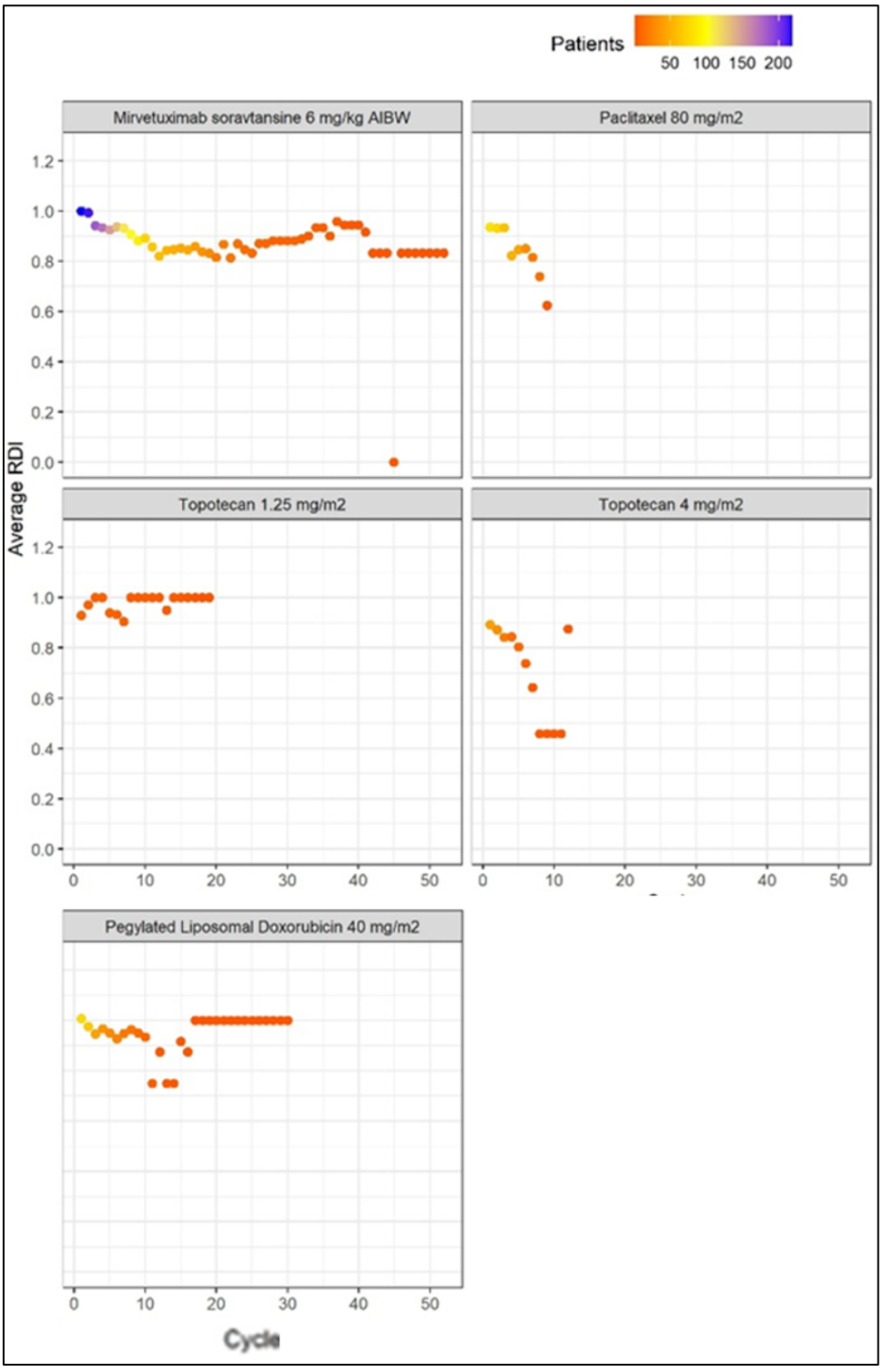
Figure 7: Per-cycle relative dose intensity



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9. Subgroup Analysis	The Committee concluded mirvetuximab may be more clinically effective in people with a primary platinum-free interval (PFI) of more than 6 months. The platinum free interval is defined as the time between the final dose of platinum chemotherapy to the date of disease progression or relapse after that line of therapy. If this interval is less than six months, this is defined as “platinum-resistant”, meaning the cancer is unlikely to respond to further platinum chemotherapy. If this interval is more than six months, this is defined as “platinum-sensitive,” meaning the tumour is anticipated to respond again to another line of platinum treatment. In the MIRASOL trial, the eligible population for mirvetuximab is exclusively patients with platinum resistance, aligned to the label. **MIRASOL Study Population** **Primary** platinum-free interval was defined as the time from last dose of **first-line** platinum therapy to the date of disease progression or relapse after first-line therapy. Patients eligible for mirvetuximab are a mixture of patients who became platinum-resistant at first line (i.e. had a primary PFI≤6 months), and patients who became platinum resistant during a subsequent line of platinum chemotherapy (i.e. had a primary PFI>6 months). The patient population with a primary platinum-free interval of less than 6 months was heterogenous, as it included patients with 1–3 previous lines of treatment. A patient with a primary platinum-free interval of less than 6 months could have been enrolled into the trial either after their first line of platinum therapy, or, could have received up to two subsequent non-platinum treatment lines after their first line of platinum chemotherapy, before enrolling onto MIRASOL. As a result, this population included patients who received mirvetuximab as their second (13%), third (40%) or fourth line treatment (48%). Hence, drawing conclusions on the efficacy of mirvetuximab based on the primary platinum-free interval is very difficult given the mixed patient population. In addition, primary-platinum-free interval was not a stratification factor and therefore all results should be interpreted with caution as subgroup factors that were not stratification factors were subject to confounding bias as randomisation may be broken. Furthermore, results for PFS, ORR, OS, and PFS2 across subgroups were broadly consistent with those of the primary analysis using the intent-to-treat (ITT) population, while, based on the p-value for treatment effect, the primary platinum-free interval subgroup results were inconsistent, with OS statistically significant but not PFS. AbbVie therefore disagrees that mirvetuximab may be more clinically effective in people with a primary platinum-free interval of more than 6 months. Clinicians also highlighted that subgroup analysis should not be over-interpreted, and that they would consider patients with primary PFI ≤6 months as eligible for mirvetuximab, as the goal would be to give them the treatment with the best efficacy, which is demonstrated by the observed benefits within the MIRASOL ITT population. As such, a restriction on mirvetuximab based on primary PFI more than 6 months would effectively exclude patients from receiving mirvetuximab at second-line treatment, but also exclude any women with a PFI≤6 months who have already received treatment for their platinum resistant disease in a second or third line setting.

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	Conclusion In summary, the subgroup analyses in MIRASOL were exploratory only, unstratified, and as highlighted by the clinical experts, should be interpreted with caution. As such the analyses were not powered to be able to draw the conclusion that mirvetuximab is more clinically effective in patients with primary PFI >6 months, and doing so would exclude a significant proportion of eligible patients with a high unmet need who would otherwise benefit from mirvetuximab. The critical unmet need in PROC is also recognised within the clinical community, as evidenced by the British Gynaecological Cancer Society (BGCS) guidelines and the UK Gynae Trials Group (GTG) key strategic priorities that emphasise the need for more effective, less toxic and biomarker-led treatment options (47, 48). Therefore, mirvetuximab should be offered as a treatment option to all patients with high FR-α positive PROC who have received 1 to 3 prior lines of treatment. For completeness, the cost-effectiveness results for subgroups based on primary platinum-free interval are presented in Appendix 1; baseline characteristics based on primary platinum-free interval (as requested by the Committee in the DGD) are presented in Appendix 5.

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Use this comment form and submit it as a Word document (not a PDF).
Complete the disclosure about funding from the company and links with, or funding from, the tobacco industry.
Combine all comments from your organisation into one response. We cannot accept more than one set of comments from each organisation.
Do not paste other tables into this table – type directly into the table.
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Do not include medical information about yourself or another person from which you or the person could be identified.
Do not use abbreviations.
Do not include attachments such as research articles, letters or leaflets. For copyright reasons, we will have to return comments forms that have attachments without reading them. You can resubmit your comments form without attachments, it must send it by the deadline.
If you have received agreement from NICE to submit additional evidence with your comments on the draft guidance document, please submit these separately.
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APPENDIX 1: UPDATED BASE CASE AND RESULTS

Updated base-case settings

Changes to the company base case are presented in Table 6. Further details on utility values used in the revised company base case are provided in Section 2.

Table 6: Changes to AbbVie's base case

Item	Previous company base case†	Revised company base case
Utilities for IC Chemo	Havrilesky et al (3)	MIRASOL utilities with treatment effect interaction
Cost of topotecan	Included	Excluded (aligned with Committee)
Age	59	63 (aligned with Committee)
Gynaecology visits post progression	Every 3 months	Every 6 weeks (aligned with Committee)
Mirvetuximab as subsequent therapy	Included	Excluded from subsequent therapies; the IC Chemo arm has also been adjusted for crossover (aligned with Committee)
AE disutilities	Excluded	Included (aligned with Committee); disutility for alopecia included
Cost of fatigue	Included	Excluded (aligned with Committee)

†The previous company base case reflects the updated base case included in the response to the EAG's clarification questions.
Abbreviations: AE, adverse event; EAG, External Assessment Group; IC Chemo, Investigator's choice of chemotherapy.

Updated results

Results for the revised company base case are presented in Table 7; [redacted] Results are also presented for key scenario analyses discussed throughout this response document.

Table 7: Updated cost-effectiveness results

	ICER		
	Severity modifier: 1.7	**Severity modifier: 1.2**	**No severity modifier**
Previous company base case	[redacted]	[redacted]	[redacted]
Revised company base case, incorporating revised PAS discount	[redacted]	[redacted]	[redacted]
Scenario: Utility model including PFS2 approach	[redacted]	[redacted]	[redacted]
Scenario: Using Kaplan Meier for mirvetuximab TTD	[redacted]	[redacted]	[redacted]
Scenario: PPFI ≤6 months	[redacted]	[redacted]	[redacted]
Scenario: PPFI >6 months	[redacted]	[redacted]	[redacted]

Abbreviations: ICER, incremental cost-effectiveness ratio; OS, overall survival; PPFI, primary platinum-free interval; TTD, time to treatment discontinuation.

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APPENDIX 2: RWE FOR CHEMO OS

Overall survival for IC Chemo

The DGD states that "it would be useful to have alternative data sources for pooled chemotherapy to help validate the pooled chemotherapy OS extrapolations". Two relevant sources of OS data were identified:

- The comparator arm in the AURELIA trial (comprised of paclitaxel, pegylated liposomal doxorubicin, and topotecan)
- RWE from the Nicola Murray Centre for Ovarian Cancer Research.

Maximum follow-up for both data sources is less than is available for the IC Chemo arm of MIRASOL (Table 8); these sources can therefore not be used to validate the long-term extrapolation of IC Chemo data. However, the RWE study may be considered relevant for informing the calculation of the severity modifier.

Table 8: Maximum follow-up time for alternative data sources

	Maximum follow-up (months)
IC Chemo arm of MIRASOL (15)	40
Comparator arm of AURELIA (50)	36
RWE study (21)	36

Abbreviations: IC Chemo, investigators choice of chemotherapy; RWE, real-world evidence.

A retrospective analysis has been conducted by the Nicola Murray Centre for Ovarian Cancer Research, characterising the real-world outcomes of a cohort of patients with PROC treated at the Edinburgh Cancer Centre (21). A total of 301 patients met the inclusion and exclusion criteria for the study (total PROC cohort), with 228 of these patients receiving treatment following a platinum-resistant relapse (treated PROC cohort; see Figure 8**).**

Of these patients, 68 patients received bevacizumab-containing regimens, and 160 patients received treatments not containing bevacizumab; as the IC Chemo arm of MIRASOL consisted of single-agent chemotherapies, the sub-population of patients who did not receive bevacizumab was considered most comparable. Median OS in this sub-population was 9 months, and the OS Kaplan Meier is presented in Figure 9**.**

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Figure 8: Case flow diagram of cohort identification

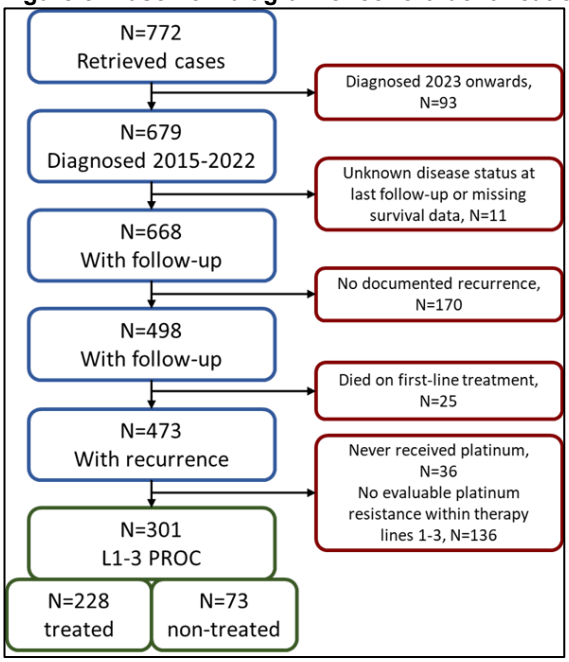
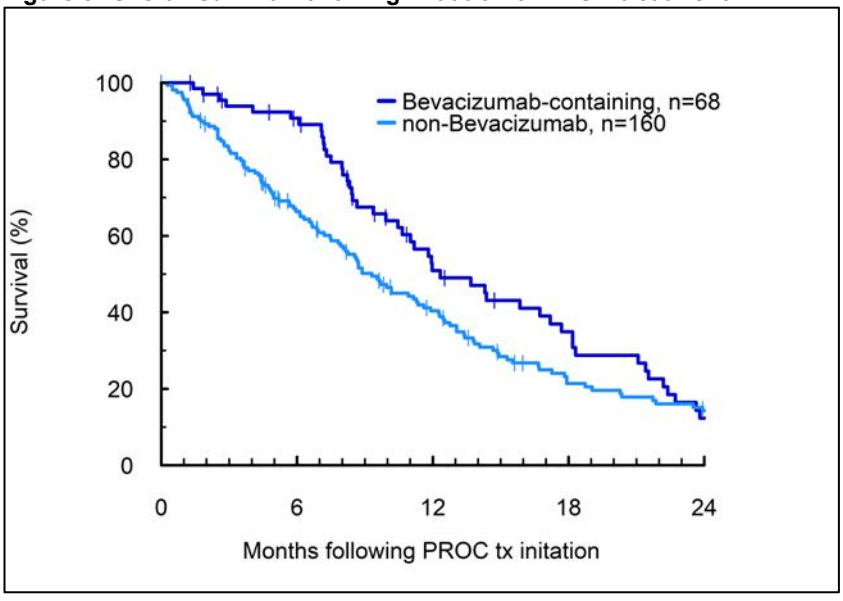


Figure 9: Overall survival following initiation of PROC treatment



APPENDIX 3: GOODNESS OF FIT STATISTICS

Table 9: Goodness of fit statistics – utility models

	Treatment specific model	Treatment specific model plus interaction term
-2 Log Likelihood	-1590.08	-1596.07
AIC	-1578.08	-1582.07
AICC	-1578.05	-1582.02
BIC	-1554.02	-1553.99
CAIC	-1548.02	-1546.99
HQIC	-1568.56	-1570.96

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APPENDIX 4: SUPPORTIVE INFORMATION FOR VIAL SHARING

THE CURRENT CLINICAL PATHWAY SUPPORTS THE VIAL SHARING PROCESS

Insights gathered from 7 pharmacists based in NHS gynaecological oncology centres indicate that vial sharing can be achieved through clinic scheduling and coordination with aseptic pharmacies. Centres use scheduling to allow the alignment of patients without delaying treatment, with ovarian cancer patients attending clinics on specific days. The pharmacists consulted by AbbVie advised that due to the specialised nature of PROC management, the centralisation of treatment in high volume oncology centres meant just two patients attending clinic on the same day would support vial sharing in practice. As the current treatment pathway enables same day preparation for multiple patients, it is anticipated that this approach would also be feasible for patients with PROC receiving mirvetuximab.

THE NHS ENCOURAGES VIAL SHARING PRIMARILY TO ACHIEVE COST SAVINGS AND REDUCE MEDICINE WASTAGE (51)

This is particularly the case with higher-cost drugs, such as some cancer medicines including trastuzumab deruxtecan and mirvetuximab if reimbursed. This practice not only optimises public resource allocation but also helps manage medicine shortages.
Key reasons for vial sharing include:

- **Cost efficiency:** High-cost injectable medicines are often supplied in single-use vials that contain more product than a single patient's prescribed dose, leading to significant leftover waste. Vial sharing allows the contents to be used for multiple patients, minimising this financial waste.
- **Resource management:** Through production batching and vial sharing, the NHS can better manage and optimise inventory, thus reducing the risk of any medicine’s shortage.
- **Incentives and policy:** NHS England has previously provided incentives and "gain share" schemes to encourage provider Trusts to adopt efficient practices like vial sharing and reduce overall spending on cancer medicines.

CANCER MEDICINES ARE PREPARED UNDER ASEPTIC CONDITIONS AND PRODUCTION BATCHING (INCLUDING VIAL SHARING) AS A MECHANISM FOR ENSURING PATIENT SAFETY AND PREVENTING CONTAMINATION

An aseptic pharmacist that AbbVie consulted, described the multi-stage process when entering a sterile unit, to avoid inadvertent contamination of oncology medicines when being re-constituted. This procedure is governed by standard operating procedures (SOPs) and professional standards such as Quality Assurance of Aseptic Preparation Services (QAAPS) (52).

The aseptic pharmacist explained that the whole process is very laborious and therefore an attempt will always be made to ‘batch produce’ where feasible.

Insights gathered from pharmacists based in NHS gynaecological oncology centres indicate that vial sharing can be achieved through clinic scheduling and coordination with aseptic pharmacies. Centres use scheduling to allow the alignment of patients without delaying treatment, with patients with OC attending clinics on specific days. As the current treatment pathway naturally enables same day preparation for multiple patients, it is anticipated that this approach would also be feasible for patients with PROC receiving mirvetuximab.

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APPENDIX 5: BASELINE CHARACTERISTICS BY PPFI SUBGROUP

Baseline characteristics by PPFI subgroup are presented in Table 10.

Table 10: Baseline characteristics of MIRASOL, by primary platinum-free interval†

	IC Chemo		Mirvetuximab			Overall		
Primary platinum-free interval	<= 6 months	> 6 months	<= 6 months	> 6 months	Missing	<= 6 months	> 6 months	Missing
	[redacted]							
Age								
Mean (SD)	[redacted]							
Median [Min, Max]	[redacted]							
Pooled Age Group 1								
>= 65	[redacted]							
18–64	[redacted]							
Race								
Asian	[redacted]							
Black Or African American	[redacted]							
Not Reported	[redacted]							
White	[redacted]							
Other	[redacted]							
Ethnicity								
Missing	[redacted]							
Hispanic Or Latino	[redacted]							
Not Hispanic Or Latino	[redacted]							
Not Reported	[redacted]							
Unknown	[redacted]							
Primary Diagnosis								
Epithelial ovarian	[redacted]							

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Fallopian tube	[redacted]							
Primary peritoneal	[redacted]							
Other: tuba ovarian origin	[redacted]							
Other: tubo-ovarian primary	[redacted]							
Other: tubo-ovarian	[redacted]							
Stage at Initial Diagnosis								
Missing	[redacted]							
Stage IA	[redacted]							
Stage IC	[redacted]							
Stage IIA	[redacted]							
Stage IIB	[redacted]							
Stage IIC	[redacted]							
Stage IIIA	[redacted]							
Stage IIIB	[redacted]							
Stage IIIC	[redacted]							
Stage IV	[redacted]							
ECOG Performance at Baseline								
Missing	[redacted]							
0	[redacted]							
1	[redacted]							
2	[redacted]							
BRCA								
Negative/ unknown	[redacted]							
Positive	[redacted]							
Stratified Prior Lines of Therapy								
1	[redacted]							
2	[redacted]							

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3	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Missing	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Prior Exposure to Bevacizumab Flag								
N	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Y	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Prior Exposure to PARP Inhibitors Flag								
N	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Y	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Prior Exposure to Taxanes Flag								
Y	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
N	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Prior Exposure to Doxorubicin Flag								
N	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Y	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Prior Exposure to Topotecan Flag								
N	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Y	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Platinum-free interval								
<= 3 months	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
>3 to <= 6 months	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
> 6 months	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

†Data generated from individual-patient data.
Abbreviations: cat, category; Eastern Cooperative Oncology Group (ECOG); Investigator's choice of chemotherapy (IC Chemo); PARP, poly (ADP-ribose) polymerase; SD, standard deviation.

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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single technology appraisal

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]

Addendum

March 2026

File name	Version	Contains confidential information	Date
ID6442_Mirvetuximab_PROC_addendum_REDACTED	2.0	Yes	02/03/2026

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1 Overview

Following submission of AbbVie's response to the Draft Guidance, AbbVie received additional evidence from NICE in the form of a SACT report, and an EAG report with analyses and conclusions drawn from this. This addendum provides further analyses of the SACT data and additional commentary to help inform the committee's decision making. These are summarised as follows:

Main Conclusion	Description
SACT data adequately captures the survival over time of PROC patients receiving standard of care chemotherapy	The SACT data is reflective of the median survival of chemotherapy expected in NHS clinical practice and aligns with other real world evidence datasets and clinical expert estimations. Thus, it is a plausible source to support decision making.
The log-logistic curve provides the best statistical fit to the SACT data and a good visual fit	Based on AbbVie's analysis, the log-logistic curve fits the SACT data best and shows a very small proportion of long-term survivors on chemotherapy.
AbbVie preferred RWE scenario: application of MIRASOL trial treatment effect to the SACT data	Following receipt of the SACT dataset and given committee discussions regarding the selection of extrapolation models in both the chemotherapy and mirvetuximab arms of the MIRASOL trial, AbbVie have explored further the EAG scenario applying the hazard ratio from the MIRASOL trial to the SACT data to generate the mirvetuximab survival estimations. This represents a more pessimistic scenario than the company base case, but utilises evidence based on outcomes for patients treated in clinical practice and represents the AbbVie preferred scenario based on real-world data.

Sensitivity analysis exploring missingness of data demonstrates robustness of interaction-term utility values	To address the EAG's concern surrounding the mixed model for repeated measured (MMRM) which assumed data were missing at random (MAR), exploratory sensitivity analyses testing different approaches to account for the missing data were conducted. This demonstrated a consistent increased post-progression QoL difference even under conservative assumptions regarding missing data.
The impact of caregiving in PROC should be reflected in the analysis	We welcome the EAG's efforts to incorporate caregiver disutilities in the model. We note that this has been applied to 39% of patients, but given the significant likelihood that this value is higher we have conservatively updated our base case to 70% and explored the EAG's scenario of 100%.
The anticipated patient numbers and alignment of patients in the management of PROC support vial sharing	The anticipated patient numbers for mirvetuximab are broadly similar to TA704, where an assumption of 50% vial sharing was approved for the first indication of trastuzumab deruxtecan. The patient uptake of mirvetuximab is now anticipated to be much quicker than original AbbVie estimates based on recent clinical insights and driven by the very high unmet need in PROC. In addition, the centralised specialist management of PROC and clinic scheduling support the alignment of patients, consequently providing the infrastructure to enable vial sharing. Collectively this demonstrates that an assumption of 50% vial sharing for mirvetuximab is reasonable.

Given AbbVie's aim of working collaboratively with NICE and NHS England (NHSE) to ensure patients have access to the first treatment option to demonstrate a significant survival benefit in platinum-resistant ovarian cancer in over two

decades, [redacted] has been submitted and accepted by NHSE.

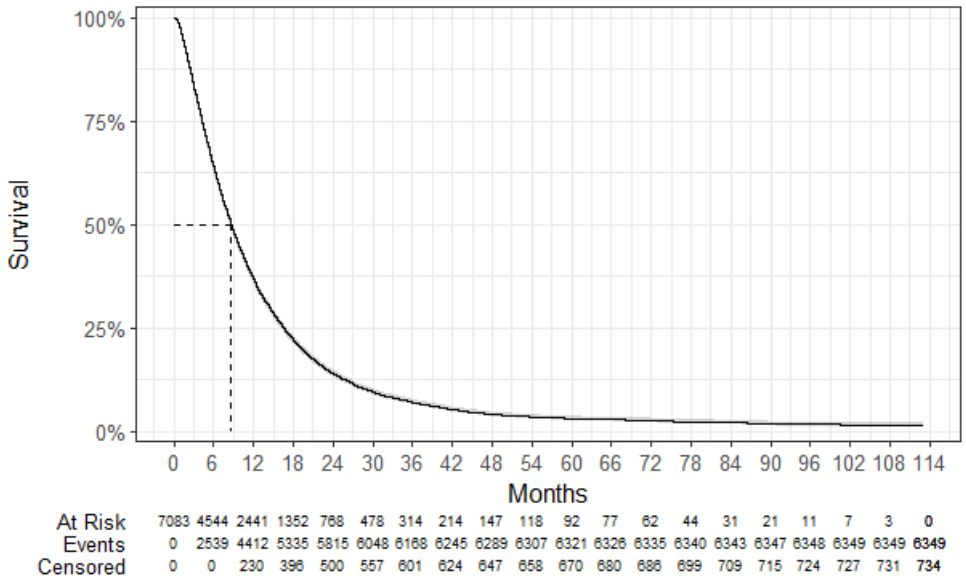
2 SACT data adequately captures the survival over time of PROC patients receiving standard of care chemotherapy

AbbVie welcomes the National Disease and Registration Service (NDRS) and National Institute for Health and Care Excellence (NICE) partnership report utilising SACT data. Key highlights include:

- A large sample size of 7,083 patients
- Maximum follow-up of 113 months, compared to 45 months in the final data cut of the MIRASOL trial
- The median survival for PLD and paclitaxel in routine clinical practice is 8.64 months and this aligns with stakeholder comments that after the onset of platinum resistance the length of life for women is in the range of 9-12 months. Furthermore, as noted in AbbVie's response to the DGD, in a retrospective analysis conducted by the Nicola Murray Centre for Ovarian Cancer Research, the median OS in the sub-population considered most comparable to the IC Chemo arm of MIRASOL was 9 months
- The Kaplan-Meier curves exhibited a pattern of steep initial hazards followed by a slowing in the long-term hazard with a small proportion (numbers at risk less than 1% of the original sample size from year 7) of patients remaining alive at 9 years. During consultations with clinical experts, there had been discussion of a minority of patients on chemotherapy described as 'super responders'. This is reflected in the relatively long tail of the K-M curve and explains why the restricted mean survival time of 14.2 months is longer than the median survival of 8.64 months.

Given the robustness of the SACT dataset capturing the survival of PROC patients over time receiving NHS standard of care, we consider this real-world data plausible to support committee decision making.

Figure 1 Overall survival amongst patients who have received PLD or paclitaxel monotherapy for PROC, SACT

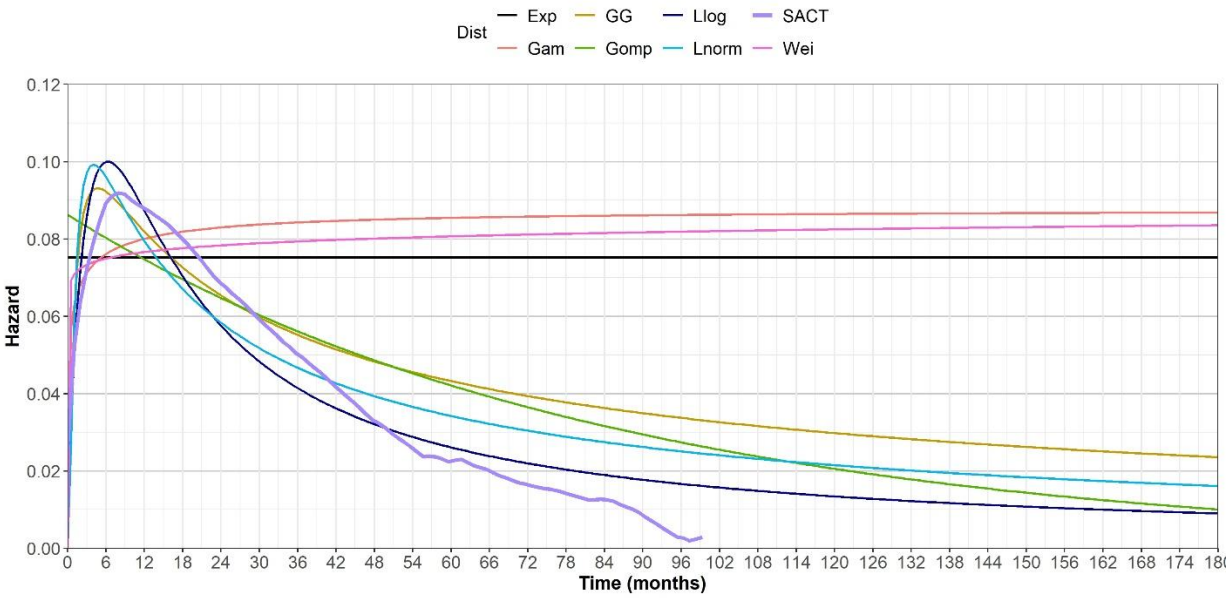


3 The log-logistic curve provides the best statistical fit to the SACT data and a good visual fit

The NDRS-NICE partnership report includes an assessment of standard parametric models fitted to the SACT data. AbbVie agrees with the EAG that the log-logistic curve provides the best statistical and visual fit to the SACT data. However, we note that the EAG's stated preference for the log-logistic curve did not include an assessment of hazards.

AbbVie has plotted the hazards from the SACT data against the hazards of all standard parametric models (see Figure 2 below). Assessing the hazards further confirms the EAG's assessment that the log-logistic curve is the most appropriate curve for modelling SACT survival.

Figure 2 SACT hazard with fitted curves



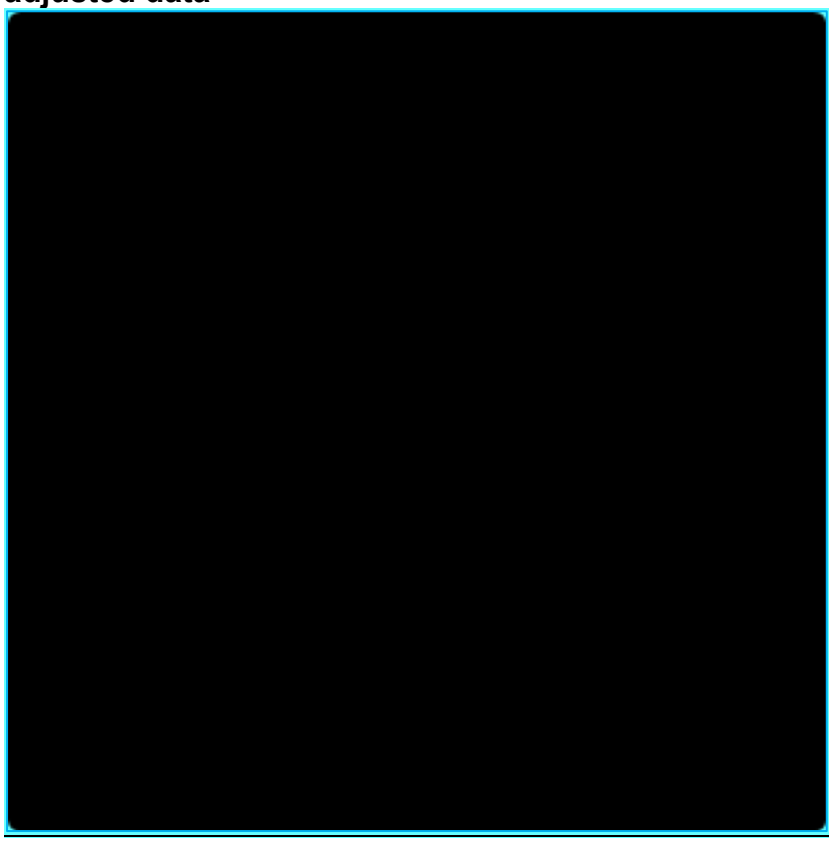
When considering how to utilise the SACT data, we agree with the EAG's stated preference to update the model to use SACT data to model outcomes for chemotherapy as this represents the data most generalisable to outcomes in UK practice and comes from a large sample size with long-term follow-up.

This represents a more robust approach than the second-best solution, of not using the SACT data at all, but instead applying log-logistic curves to both arms of the

MIRASOL trial. Of note is that this approach underestimates the treatment effect of mirvetuximab: In MIRASOL, the hazard ratio for OS was 0.68.

In the EAG base-case, the HR briefly drops below 0.7 and then stabilises at approximately 0.85 (Figure 3).

Figure 3 Treatment effect over time: EAG revised base case, using RPSFTM adjusted data



4 AbbVie preferred RWE scenario: application of MIRASOL trial treatment effect to the SACT data

As noted by the EAG, the preferred approach is to use SACT data to model outcomes for chemotherapy as this represents the data most generalisable to outcomes in UK practice and comes from a large sample size with long-term follow-up. This approach utilises the SACT data directly and applies the hazard ratio of 0.68 from the trial.

AbbVie notes that this approach is also supported by the NICE Decision Support Unit which states that "*RWD from SACT can be used to inform estimates of cost-effectiveness*".[1] The report notes that applying a hazard ratio derived from the clinical trial is a valid approach since trial-based analyses represent the best estimates of relative treatment effects. We welcome the EAG's exploration of this approach as a scenario and note that this scenario results in ICERs that are more pessimistic than the company base case, but less pessimistic than the EAG's revised base case.

Furthermore, the application of hazard ratios with SACT data or similar approaches have been used for Committee decision making in previous NICE appraisals, such as TA967 and TA1079.

Given the limitations with all proposed methods, this scenario has merit as it utilises a large real-world dataset and applies a hazard ratio which has been elicited from a robust and well-conducted Phase III RCT. Thus, it may offer the best available prediction of clinical reality once mirvetuximab is available in the UK. Overall, AbbVie support the scenario conducted by the EAG as the most robust approach to incorporate the SACT data and inform decision making. The ICER results for this alternative RWE scenario analysis is found in Section 9 (**Error! Reference source not found.**).

5 Utilities

5.1 Sensitivity analysis exploring missingness of data demonstrates robustness of base-case utility values

AbbVie agrees with the committee's observation that the MIRASOL utilities may be underestimating the QoL benefits of mirvetuximab. Currently, the MIRASOL utility values as used by the EAG suggest only a small (0.03) difference in HRQoL between patients receiving mirvetuximab and patients receiving chemotherapy. But, based on the patient and clinical expert feedback during the first committee meeting, the committee felt it was possible that the MIRASOL utilities did not fully capture the improvement in HRQoL potentially offered by mirvetuximab compared with chemotherapy. This has been further reinforced by responses to the DGD consultation, where the BGCS concluded the benefit in terms of response rate and QoL for women with platinum resistant ovarian cancer was underestimated. Similarly patient group survey responses emphasised the improved QoL with mirvetuximab.

As requested by the committee to help their decision making, in response to the DGD we explored alternative statistical methods to identify utility values that better reflect this improvement in quality of life. The method aimed to adjust utility values for progression status, based on clinical expert insights which emphasised that poor response to second non-platinum therapy at progression results in higher tumour burden and more disease related symptoms.

Given the patient and clinician feedback on the meaningful impact of mirvetuximab on QoL, we maintain that the interaction term utilities offer the best reflection of the QoL differences between treatment arms, are substantiated by clinical rationale, and we consider this to have more face validity than the small improvement suggested by the EAG's base case. However, we note the EAG's concerns regarding missing data. To address this, we conducted sensitivity analyses to explore the impact, with the methodology detailed in the Appendix. Even in highly conservative scenarios, the results consistently demonstrate the improved quality of life pre progression and further larger benefits post progression, demonstrating robustness in the modelled utility values.

5.2 The impact of caregiving in PROC should be reflected in the analysis

AbbVie appreciates the efforts of the EAG to explore the impact of caregiver utility in PROC. As outlined in our DGD response and captured in the Ovacome survey responses, both the treatment and management of PROC has a significant detrimental effect on both patients and their caregivers, and we agree this should be appropriately reflected within the analysis. AbbVie also agrees that the precise percentage of patients who have carers is uncertain. As such, we have explored an additional scenario for consideration, which assumes that 70% or 100% of patients have a carer. We have conservatively included 70% in our base case but suggest that the exact percentage would be worthy of exploration by the committee with input from patient representatives and clinicians. The ICER results of the revised base case incorporating carer disutility and additional scenario analysis are outlined in Section 9 (Table 2 and **Error! Reference source not found.**).

Please note that there was an error with the dropdown in the EAG's model which has been fixed in the version provided alongside this document.

6 The anticipated patient numbers and alignment of patients in the management of PROC support vial sharing

The EAG notes that trastuzumab deruxtecan is used across a number of indications and concludes the number of treated patients is larger than that of mirvetuximab. AbbVie would like to clarify that trastuzumab deruxtecan is currently reimbursed in two indications within breast cancer only (TA704 and TA862), with the other mentioned indications in ovarian and lung cancer either unlicensed or terminated appraisals.

While we can appreciate the differences outlined by the EAG regarding the treatment duration of mirvetuximab in comparison to trastuzumab deruxtecan, it is also worth noting the differences in the delivery of management; breast cancer management is more decentralised, with patients distributed across numerous centres. In contrast, PROC patients are more concentrated in specialised centres, meaning a larger volume of patients per centre. Further to this, according to clinical experts consulted by AbbVie, larger centres aim to coordinate ovarian cancer patients on set clinic days. Considering this in combination with the increased throughput of patients, it would be feasible to have more than one patient receiving treatment at a time, making the assumption of vial sharing plausible.

Additionally, while the EAG note the patient numbers across both TA704 and TA862 are estimated to be 600 patients, we would like to highlight that an assumption of 50% vial sharing was accepted for trastuzumab deruxtecan when the first indication was being appraised (TA704), i.e. in advance of follow-on indications. The patient numbers published in the resource impact statement for TA704 was 350 patients per year, closely aligning with the estimated mirvetuximab budget impact patient numbers between Year 1 and 3.[2]

We would also like to note that the uptake estimations in the budget impact model are considered conservative given the high unmet need in PROC, where there has been no new treatment in the past 20 years. As such, while the patient numbers are estimated to be [redacted] by Year 5, given the volume of response

[redacted] we would expect to reach these numbers earlier, between the first and second year.

In summary AbbVie maintains that 50% vial sharing in clinical practice for mirvetuximab is a reasonable and fair assumption.

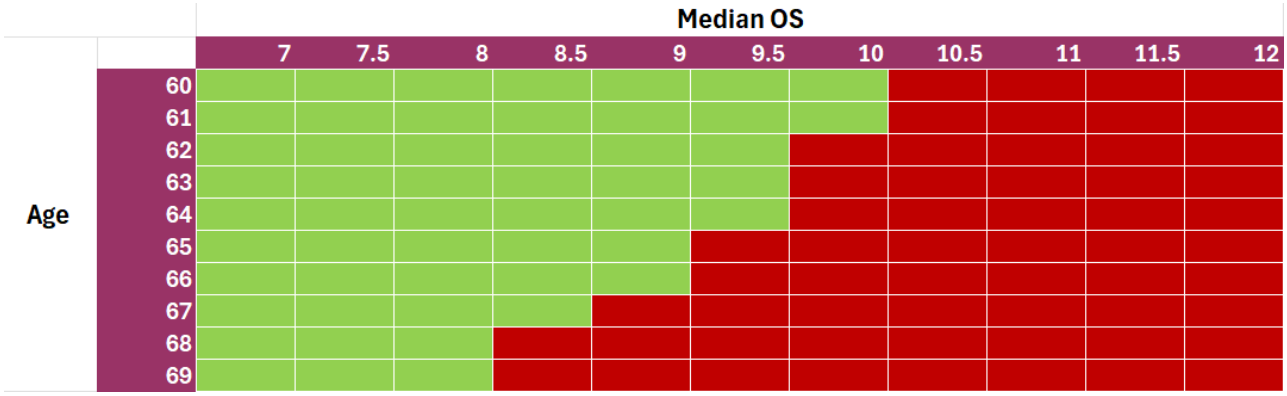
7 Is PROC a highly severe disease?

AbbVie acknowledges the standard quantitative approach to assessing QALY shortfalls and notes that the EAG assumptions estimate a proportional QALY shortfall close to the threshold of 0.95 for triggering the 1.7 modifier. The DGD response, which was submitted in advance of receiving the NDRS and NICE partnership SACT report, included a scenario analysis whereby a severity modifier of 1.7 was demonstrated when using data from RWE (Nicola Murray Centre for Ovarian Cancer Research) showing a median survival of 9 months. As noted earlier this closely aligns with the median survival of 8.64 months reflected in the SACT report. This shows that there may be some scenarios in which the severity modifier could switch from 1.2 to 1.7. The closeness of the estimated 1.2 modifier to 1.7 modifier means that in some scenarios, utilising real world evidence and reflecting the lived HRQoL of PROC patients, and rounding up to one decimal point, triggers the 1.7 modifier.

Figure 4 below shows the results of scenario analysis utilising various combinations of chemotherapy median survival and age (with utilities kept the same based on interaction term utilities). The green cells indicate all the scenarios that result in a 1.7 modifier, and the red cells indicate scenarios in which the 1.2 modifier holds.

Notwithstanding, the results of the quantitative assessment of severity, given the high unmet need, the lack of new treatment options in over 20 years and patient survey results reflecting the highly severe nature of the disease in terms of the impact on HRQoL, AbbVie would welcome the Committee’s consideration of these broader factors in the application of the severity weighting for patient access.

Figure 4 Exploring severity modifier weights at different mOS and age assumptions



Green: x1.7 applies, Red: x1.2 applies

8 Minor cost corrections

8.1 Baseline ocular assessments

The SmPC states that “an ophthalmic exam including visual acuity and slit lamp exam should be conducted before the initiation of ELAHERE”. The economic model currently includes this cost within ‘additional treatment-specific monitoring for mirvetuximab’.

To further support the introduction of Elahere to the NHS in the face of NHS ophthalmology capacity challenges, AbbVie is working with a major high-street provider to fund the costs of the baseline eye exam required for mirvetuximab. As a result, this cost should no longer be included in the economic model.

The company base case has been updated to exclude the cost of baseline ocular assessment. This results in a decrease in total monitoring costs from [redacted] to [redacted].

8.2 Administration costs

A minor error was identified in treatment administration costs.

The first administration of weekly paclitaxel in each 28-day cycle had been assumed to incur the SB12Z HRG code, which assumes *“overall time of 30 minutes nurse time and 30 to 60 minutes chair time for the delivery of a complete cycle”.* Clinical advice to AbbVie suggested that paclitaxel is relatively complex to administer, and that the SB13Z code is more suitable, which assumes *“60 minutes nurse time and up to 120 minutes chair time for the delivery of a complete cycle”.*

As a result, the first-day administration of paclitaxel has been updated to SB13Z. This approach has more face validity, given mirvetuximab, paclitaxel and pegylated liposomal doxorubicin (PLD) are similarly complex to administer. The remaining administrations of paclitaxel in each cycle maintain the SB15Z code (Table 1).

Table 1: Administration costs

Drug		Administration type	Procedure Code	Cost per administration	Reference	Revised code	Revised cost	Reference
Mirvetuximab		Complex parenteral chemo - first attendance	SB13Z	£184.31	NHS reference costs 2023/24 (201)	SB13Z	£184.31	NHS reference costs 2025/26 (201)
Paclitaxel	First day	Simple parenteral chemo - first attendance	SB12Z	£133.39		**SB13Z**	**£184.31**	
	Subsequent days	IV chemo - subsequent elements	SB15Z	£198.08		SB15Z	£198.08	
Pegylated liposomal doxorubicin		Complex parenteral chemo - first attendance	SB13Z	£184.31		SB13Z	£184.31	

9 Revised base case and scenario analyses ICER results

9.1 Revised base case

The revised base case ICER results to reflect the minor cost corrections outlined in Section 8 and to incorporate caregiver disutilities as described in Section 5.2 are found in Table 2.

Table 2: Revised base case ICER results

	ICER		
	Severity modifier: 1.7	**Severity modifier: 1.2**	**No severity modifier**
Company previous base case, incorporating revised PAS discount	[redacted]	[redacted]	[redacted]
Company base case, excluding baseline ocular assessment	[redacted]	[redacted]	[redacted]
Company base case, excluding baseline ocular assessment and correcting administration costs	[redacted]	[redacted]	[redacted]
Company revised base case, incorporating corrections and applying carer disutilities (70%)	[redacted]	[redacted]	[redacted]

9.2 Caregiver disutility scenario analysis

As discussed in Section 5.2, given the uncertainty in the exact proportion of PROC patients with carers, additional scenarios were explored. The results are outlined in **Error! Reference source not found.**.

Table 3: Scenario analysis of carer disutilities

	ICER		
	Severity modifier: 1.7	**Severity modifier: 1.2**	**No severity modifier**
Company revised base case (70%)	[redacted]	[redacted]	[redacted]

Include carer disutility for 39% of patients	[redacted]	[redacted]	[redacted]
Include carer disutility for 100% of patients	[redacted]	[redacted]	[redacted]

9.3 Preferred RWE scenario analysis

As further discussed in Section 4, AbbVie support the HR scenario conducted by the EAG as the most robust approach to incorporate the SACT data and inform decision making. The ICER results for this preferred alternative RWE scenario analysis are outlined in Table 4.

Table 4: SACT scenario analysis

	ICER		
	Severity modifier: 1.7	**Severity modifier: 1.2**	**No severity modifier**
Company revised base case	[redacted]	[redacted]	[redacted]
Alternative RWE Scenario, 39% carer disutilities	[redacted]	[redacted]	[redacted]
Alternative RWE Scenario, 70% carer disutilities	[redacted]	[redacted]	[redacted]
Alternative RWE Scenario, 100% carer disutilities	[redacted]	[redacted]	[redacted]

10 Appendix: Missingness of data sensitivity analyses

As discussed in Section 5.1, exploratory scenarios have been conducted to address the EAG's concern surrounding the mixed model for repeated measures (MMRM) used to derive utility values in the company base case which assumes data were missing at random. The scenarios explore whether the treatment effect of mirvetuximab may have differed in patients who progressed but for whom post-progression utility data are not available.

Three groups of patients were considered:

Group 1: Patients who report pre-progression data and don't progress (censored or died), or patients who report post-progression data

Group 2: Patients who report pre-progression utility data, progress but don't report post progression data

Group 3. Patients who don't report utility data pre- or post-progression

Additional analyses have been performed that consider a utility model with an interaction term for patients in the first group only, and a model of pre-progression utility in the second group. No analyses are feasible in the third group. A summary of the additional analyses is presented in Table 5.

The resulting utility values for each of the three groups are presented in Table 7. In Group 2 (i.e. patients who progressed but do not have post-progression data), utility values are numerically higher for chemotherapy patients than for mirvetuximab patients. This pattern was conservatively assumed to hold in the post-progression state. In Group 3, the treatment effect for mirvetuximab was either set to zero (approach 1) or conservatively assumed to be the same as for Group 2 (approach 2).

Based on the utility values estimated for each group, three exploratory scenario analyses were considered:

1. A weighted average of utility values for group 1 and group 2; group 3 is considered non-informative and excluded
2. A weighted average of all three groups; approach 1 is used for group 3
3. A weighted average of all three groups; approach 2 is used for group 3.

The utility values used in each of the three considered scenario analyses are presented in Table 7, with the corresponding cost-effectiveness results presented in Table 8. Modelled utility values are shown to be relatively robust to alternative assumptions, including highly conservative approaches. In each of the three scenarios, relative treatment effects pre- and post-progression are slightly reduced compared to the company base case, though benefits are still observed for mirvetuximab compared to chemotherapy in both cases. The impact on the company base-case incremental cost-effectiveness ratio (ICER) is relatively small.

Table 5: Summary of additional analyses

Group	Population of MIRASOL	Regression models generated	Estimation of health state utility values	Number of patients with pre-progression data	Number of patients with post-progression data
1	Patients who report pre-progression data and don't progress (censored or died), or patients who report post-progression data	Model fitted including covariates for treatment, health state and a treatment/health state interaction term.	Estimated directly from regression model.	Chemotherapy: 151 Mirvetuximab: 162	Chemotherapy: 106 Mirvetuximab: 137
2	Patients who report pre-progression utility data, progress but don't report post progression data	Model fitted with treatment covariate to estimate pre-progression utility	Pre-progression utility value estimated directly from regression model; post-progression utility decrement assumed to be the same as chemotherapy in group 1.	Chemotherapy: 44 Mirvetuximab: 47	No utility data reported, though all patients experience progression
3*	Patients who do not report utility data pre- or post-progression	N/A; no data available to fit a regression model.	Two alternative approaches: 1. Generate a weighted average utility estimate for chemotherapy for both health states; no treatment effect assumed 2. Assume utilities are the same as in group 2	No utility data reported. For chemotherapy: • 18 patients censored for PFS on day 1. • 8 patients progressed • 3 patients die pre-progression. For mirvetuximab: • 7 patients censored for PFS on day 1. • 2 patients censored for PFS at later date • 5 patients progressed • 2 patients die pre-progression.	No utility data reported. 8 chemotherapy patients experienced progression. 5 mirvetuximab patients experienced progression.

Abbreviations: N/A, not applicable; PFS, progression-free survival. * In group 3 seven mirvetuximab patients and 18 chemotherapy patients were censored on day 1, these patients were therefore not included in the derivations.

Table 6: Utility values in each group of MIRASOL patients

Scenario	Pre-progression					Post-progression				
	Chemotherapy		Mirvetuximab		Difference	Chemotherapy		Mirvetuximab		Difference
	N	Utility value	N	Utility value		N	Utility value	N	Utility value	
Company base case: original interaction term model	195	0.712	209	0.732	0.020	106	0.596	137	0.675	0.080
Group 1	151	0.705	162	0.738	0.033	106	0.590	137	0.686	0.097
Group 2	44	0.739	47	0.710	–0.028	44	0.624†	47	0.596†	–0.028
Group 3 – Approach 1	11	0.712‡	9	0.712‡	0.000	8	0.600‡	5	0.600‡	0.000
Group 3 – Approach 2	11	0.739¶	9	0.710¶	–0.028	8	0.624¶	5	0.596¶	–0.028

†Post-progression utility decrement for chemotherapy patients in Group 1 applied to pre-progression data for Group 2; this approach effectively assumes that the treatment effect observed pre-progression would be observed post-progression; ‡ Pre-progression utilities calculated as the weighted average of chemotherapy utility values for Group 1 and Group 2, post-progression utility decrement assumed to be the same as chemotherapy in group 1; no treatment effect assumed pre- or post-progression; ¶ Utility values in Group 3 assumed to be the same as in Group 2

Table 7: Utility values used in scenario analyses

Scenario	Pre-progression utility value			Post-progression utility value		
	Chemotherapy	Mirvetuximab	Difference	Chemotherapy	Mirvetuximab	Difference
Company base case: original interaction term model	0.712	0.732	0.020	0.596	0.675	0.080
Scenario 1: Weighted average of Group 1 and 2	0.712	0.732	0.019	0.600	0.663	0.063
Scenario 2: Weighted average of all groups, no treatment effect in Group 3	0.712	0.731	0.018	0.600	0.662	0.062
Scenario 3: Weighted average of all groups, same treatment effect in Group 3 as in Group 2	0.714	0.731	0.017	0.601	0.661	0.060

Table 8: Results for scenario analyses

	ICER		
	Severity modifier: 1.7	**Severity modifier: 1.2**	**No severity modifier**
Company base case: original interaction term model	[redacted]	[redacted]	[redacted]
Scenario 1: Weighted average of Group 1 and 2	[redacted]	[redacted]	[redacted]
Scenario 2: All groups, no treatment effect in Group 3	[redacted]	[redacted]	[redacted]
Scenario 3: All groups, same treatment effect in Group 3 as in Group 2	[redacted]	[redacted]	[redacted]

11 References

1. Metry A, Latimer N, Wailoo A, Tappenden P. (2025) Real-world evidence (RWE) at NICE: Demonstrating methods for using the systemic anti-cancer therapy (SACT) dataset in technology appraisals. Report by the Decision Support Unit.
2. National Institute for Health and Care Excellence (NICE). Trastuzumab deruxtecan for treating HER2-positive unresectable or metastatic breast cancer after 2 or more anti-HER2 therapies. TA704. 2021

ovacome..

The ovarian cancer support charity

Community perspective survey summary

The survey collected survey responses from 145 members of the Ovacome community in the UK between 19th December 2025 and 16th December 2026. The survey was called 'Have your say on availability of a treatment for patients with platinum resistance'.

Many respondents would have been undergoing treatment and often choosing family time at that stage of disease. This, therefore, represents (from our perspective) a decent sample size. The total number of members of Ovacome (i.e. those who are registered as members who are also affected by ovarian cancer) is 5,600 people. However, many people access our services anonymously and are not members. The survey was promoted to our members and others who access our services. Therefore, this was less likely to be a self-selecting group of people who often engage in research and more likely to include responses from people who would ordinarily feel less able to self-advocate. We made it possible to access the survey by offering calls with our support team and interpreters or translators.

We have removed responses where they contained information that gave identifiable information but kept in all the answers where this could be removed and retain the intended meaning.

In this survey we were consulting with a group of people who are generally unfamiliar with the possible availability of treatment at point of Platinum resistance. For a small number of respondents there was confusion around terminology – eg; using the term PARPs when referring to other forms of treatment. We have not corrected this but would like it noted.

The feedback gathered from our community has focused mainly on the:

- Day to day and long-term side effects of chemotherapy – the severity of these side effects.
- The views expressed by members of our community as to the availability of treatments for ovarian cancer at the later stages of disease, specifically platinum resistance.
- Their opinions as to availability of treatments at point of platinum resistance (specifically relating to Mirvetuximab).

The NICE committee identified the following specific areas where further evidence would be helpful in their decision making:

- The impact of chemotherapy on people's quality of life. This is included below.
- The impact of mirvetuximab on people's quality of life. This is included below.
- Any reasons why the trial of mirvetuximab (MIRASOL) may not capture the quality of life of people having mirvetuximab and chemotherapy. We did not ask this question.

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Because Mirvetuximab has not been widely available to this community of people there are few people who are able to make a comparison between the side effects of Mirvetuximab and Chemotherapy. However, feedback from our community alongside this survey is that the frequency of treatment (ie 3 weekly for Mirvetuximab versus often weekly for chemotherapy) is favourable at this stage of the disease and that the side effect profile is favourable too – given that chemotherapy is so incredibly debilitating for so many. We received one comment noting negative side effects of Mirvetuximab but the rest of the responses noted fewer side effects and where there were side effects, they were better tolerated than chemotherapy. This is especially important at this stage of disease because people understand that they probably have limited time and want to make the best of it with family and friends. Likewise, for those who did not have the possibility of treatment at the point of platinum resistance (i.e. family members who had a relative die of ovarian cancer prior to Mirvetuxumab availability through trial or compassionate access) were also able to respond.

Survey results in italics, narrative explanation in normal text.

Participant breakdown

Survey participants were able to select more than one answer. This reflects the hereditary nature of the disease (eg it is possible to be a relative of someone diagnosed and also the patient diagnosed themself) and the fact that some respondents were reflecting on different stages of treatment. For completeness we have supplied all anonymised data in a spreadsheet alongside this narrative report.

Tell us who you are (please select all that apply)

Answered: 145 Skipped: 0

I am having chemotherapy for ovarian cancer	*26.21%*
I am a healthcare professional working with ovarian cancer patients	*3.45%*
Other (please specify): (See below for list)	*7.59%*
I have been diagnosed with ovarian cancer	*66.90%*
I have platinum-resistant ovarian cancer	*26.90%*
I have taken mirvetuximab soravtansine (Elahere)	*4.14%*
I am a family member or friend of someone with ovarian cancer	*11.03%*

If other, please specify

I will soon, be having chemotherapy for ovarian cancer, soon, but not yet.
My sister died from ovarian cancer
I am BRCA1 positive

Brother of Sister who died from Ovarian Cancer in 2010
I had ovarian cancer and am in remission
Having Immunotherapy
3 weekly Avastin infusion paid for due to NICE delay (approved and free in Scotland)
My mum passed away in 2024 from ovarian cancer, this being found at end stage 3
Diagnosed with a borderline ovarian tumour in 2025
Diagnosed with ovarian cancer Jan 2015
I have had chemotherapy
Presently on Olaparib, in remission.
My wife recently passed away from Ovarian Cancer at the age of 46.

The side effects of chemotherapy.

Please tell us about the side effects of chemotherapy with regard to your mobility (was it easy to walk around or move?) 94 responses

No bad effect from chemotherapy	*21.28%*
Some effect from chemotherapy	*43.62%*
A significant effect from chemotherapy	*35.11%*

How people answer this can depend on how much support they have in place. Mobility issues most commonly relate to chemotherapy induced peripheral neuropathy and fatigue. Both of these side effects can endure long after chemotherapy has finished and some people never recover, even partially, from these side effects. Over 78% of respondents noted some or significant effect on mobility. Please note that some people who have chemotherapy have side effects from the medication given to them to help them with the side effects of chemotherapy.

The following are just some of the 65 written responses:

- *I am writing this on behalf of my mother- the effects were awful. Terrible nausea, severe weakness, hardly able to get out of bed some days*
- *Have peripheral neuropathy in my feet which affects my mobility. I also get short of breath on exertion, particularly going up hill. I do not have the energy to carry out activities as I used to do prior to being diagnosed*
- *Neuropathy, leading to treatment being discontinued*
- *I was tired/exhausted for years and years afterwards, so tired that walking around shops I would pass out. I needed 12 hours sleep per day even 10 years afterwards.*
- *Extreme fatigue from one set in particular Neuropathy*
- *I developed an allergy to carboplatin whilst having my second course of chemo in 2022. My cancer returned this year and I developed another allergic reaction to carboplatin during round 3 and despite the desensitising process, was unable to tolerate the*

carboplatin during round 4. It has been decided that I will not be rechallenged with any platinum-based drugs. I am going to try and get through the last 2 rounds of paclitaxel but am struggling to cope with the side effects.

- *My mother had her 1st dose of carboplatin/paclitaxel and a few days later was in ICU fighting for her life with neutropenic sepsis. Fortunately she survived but spent 2 months as an inpatient. Before chemotherapy she was performance status 0, looking after 4 grandchildren and fully independent. After that first dose of chemotherapy she is now dependent in most ADLs, is housebound and totally a changed person. She has continued on chemotherapy at lower doses or altered regiment (now one weekly paclitaxel).*
- *Chemo left me out of breath. I couldn't walk upstairs & could only walk very short distances. I also suffered from neuropathy*
- *I am massively fatigued and deconditioned after chemo. I cannot walk for more than 1minute (timed) without getting breathless with an elevated heart rate up to 130. I have to crawl up the stairs.*
- *I don't have much energy and walk slowly. I feel vulnerable and don't like going out by myself.*
- *I cannot stand for long periods of time or walk long distances anymore. This restricts the activities I can do with my grandchildren, a great sadness for me personally.*
- *My chemo caused large blisters on my toes. My chemo treatment was postponed because the nurses viewed this as an open wound. Additionally I had to reduce my daily walking routine- to let the current blisters heal, & prevent further blisters occurring.*
- *Unable to drive or walk very far as a side effect for approx. half of time between treatments*
- *Painful feet and legs when walking.*
- *Neuropathy in my feet for 5 years now.*
- *Steroid side effects: terrible bone/joint pain - only managed 10/18 Avastin Brain fog*
- *Wiped out in first week so could only manage very short walks*
- *I had 6 cycles of Carboplatin and Paclitaxel, The pain in my legs was so painful it left me bedbound for several days after each treatment.*
- *Initially apart from fatigue I was mobile but I now have substantial nerve damage and have great difficulties walking - this damage is thought to be treatment related*
- *I have Neuropathy as a result of treatment and use a stick now.*

Please tell us about any side effects of chemotherapy with regard to self care (did it affect your ability to look after yourself)? 94 responses

No bad effect from chemotherapy	*38.30%*
Some effect from chemotherapy	*37.23%*
A significant effect from chemotherapy	*24.47%*

Responses often noted the need to have carers or family members to support them with basic tasks. For some, the side effects of chemotherapy mean that they give up work or have to bring in carers. Even when family members are providing significant levels of personal care this had an impact on the whole family dynamic, on relationships and on finances.

Responses included:

- *It did have an effect on my mother looking after herself I was with her 24/7 to help her even get out of bed etc*
- *Needed help with showering, drying etc. Not able to stand for long periods of time to cook meals and the like*
- *Lack of energy and inclination to cook*
- *I could not walk far. It affected my muscles and my energy levels. I was very weak*
- *Tiredness sometimes means that my husband needs to do things that I would otherwise have done myself*
- *So tired/exhausted that my husband had to do everything for me, cooking, shopping etc, I spent such a lot of time sleeping, 12 hours at night plus several hours in the daytime.*
- *I remained fully independent, and capable of all normal activities of daily living, and able to play golf and take a weekly dance fit class.*
- *Complete loss of taste for first 10 days after chemo. Constipation/diarrhoea for first 10 days. Severe pain in legs and feet making it difficult to walk during days 4-8. Pain in back and chest. Nausea for first week. Severe fatigue for at least first 10 days.*
- *Difficult to shower due to breathlessness and ability to safely stand long enough to shower*
- *Difficult to put socks and inderwear on. Also difficult to fasten buttons.*
- *It's been hard to live a normal life*
- *From my 3rd cycle to my last I did not have the energy ir strength do anything, it was made worse bybthe fact I live alone.*
- *Fatigue made everything tiring & needing rest/recovery, especially when haemoglobin low.*
- *For some days after treatment I was grateful to not live alone. This includes having to have injections, not being able to cook or not wanting to prepare food, no energy to do housework or look after pets. I can't imagine how people living alone cope.*
- *My husband has to do everything for a few days after my chemo*
- *She now requires assistance with showering, and due to the peripheral neuropathy from chemotherapy is unsteady on her feet too, unable to walk up stairs and needing support walking on the straight.*
- *Couldn't do my housework I had to have someone come in to do the basics.Couldn't lift my legs to get in the bath.*

- *Yes I need my wife to prepare all my meals, drinks, take me to appointments, do all the housework and help me manage my medications and pain relief. She runs baths for me and massages my legs when I can tolerate it.*
- *Not able to continue my cottage cleaning business without significant help or walk my dog or take as much exercise*
- *I have to use a seat for a shower and mist days can only strip wash, sometimes with help.*
- *Sickness and diaherra along with malaise made looking after themselves impossible*
- *Joint aches particularly low back pain limit walking and bending to the floor for foot care. I need to regularly see a podiatrist for nail cutting as chemo has made the nails thick and mishappen*
- *It meant I needed a lot of help from my husband.*
- *Had to break up jobs into small sections, rather than performing the whole ftom start to finish.*
- *It was difficult to find joy in life. I still went through the motions, but with limited enjoyment.*
- *Fatigue meant that I had to sleep for several hours a day and I felt guilty that I could not do much at all. I could not work*
- *Shaking useless hands Twitching in legs Nump feet*
- *Unable to do the things I usually did so could no longer work. Devastating effect on my mental health*
- *I needed a private care service to come and help me with personal care in the first few days after chemo. I was unsteady on my feet and nauseous. I did not expect side effects to be that serious.*
- *Unable to prepare or cook food due to fatigue, pain and feeling unwell. Struggling to maintain healthy weight. Unable to shop independently due to feeling unwell, pain and fatigue and immunosuppression.*
- *Joint stiffness in my hands make it difficult to cook, shop, and wash*

Please tell us about any side effects of chemotherapy with regard to you doing the things that are important to you. We mean every day things like time with friends and family, work, study or leisure activities. 93 answers

A significant effect from chemotherapy	*48.39%*
No bad effect from chemotherapy	*6.45%*
Some effect from chemotherapy	*45.16%*

Just 6.45% reported no bad effect on their everyday lives from Chemotherapy, for some people this has been a sustained change – beyond the duration of treatment. This is often reported to us

at Ovacome as the reason why people choose to stop treatment when they become platinum resistant; the inability to continue life and maintain important relationships and a degree of connection to important things means that the negatives associated with the side effects of chemotherapy come to outweigh the positives of continuing treatment. The isolation reported by many people on chemotherapy is often particularly affecting.

- *It had a significant effect on. Apart from hospital visits my mother was not well enough to go out during chemo*
- *I am no longer able to participate in sports as I used to. Have had to give up my badminton sessions with husband and friends. I am no longer able to participate in gym sessions. I don't eat out very often due to taste changes. I don't have the energy to enjoy shopping so have had to resort to online purchases*
- *Less interest in friends and activities I would normally participate in*
- *Normal life is on hold with chemo. I didn't go out much and I couldn't work, exercise or socialize.*
- *I did not feel like being sociable or doing the things I enjoy when I am in pain. I suffered from stomach issues, bloating, pain, mouth ulcers, acid reflux, & mucositis.*
- *I couldn't work but took early retirement, too tired to enjoy physical activities, eg dancing, swimming, walking and hiking. It took 10 years before I became stronger and able to cope with everything.*
- *I can't make any arrangements to see friends/family for at least 10 days after chemo. I then have to be very careful the week before chemo not to get tired in order to make sure that my neutraphils are high enough to have the treatment.*
- *Any cycle of chemotherapy brings a cycle of fatigue and lack of focus. The following week after treatment is the worst for concentration and fatigue but regular mild exercise helps. It is a matter of being aware of management strategies. However, the burden can be significant and prolonged.*
- *Difficult to socialise with friends and family. Had to give up work. Unable to pursue leisure activities*
- *Self isolate due to lowered immune system. Breathless, joint/bone pain, facial rash*
- *Too sick most of the time to do things*
- *The effects were in the 10 days after each cycle. Fatigue has been a lasting symptom.*
- *Had to cancel a range of social activities and less frequent exercise because of fatigue*
- *For the frontline and second line Chemo I was not able to work at all. I struggled to socialize for some of the time as for 2 weeks did not feel well enough. Your life literally goes on hold while you have treatment.*
- *I became quite isolated*
- *I used to love walking but now it is a struggle.*
- *Become housebound for a few days , quality of life very low*

- *She is unable to leave the house again due to unsteadiness on her feet, likely from peripheral neuropathy but also reconditioning having been so ill from the first round of chemotherapy. Therefore any social interaction has to be people visiting her, not the other way round.*
- *Friends came to visit me I couldn't go out to meet them I felt isolated as all I did was sit on the settee as was exhausted all the time*
- *I can't concentrate or focus on things so my hobbies have dropped. I don't get out much as I'm too exhausted and it's really hard to plan as I don't know how I'll feel until the last of the 3 week cycle. Then it's time for appointments and chemo again .*
- *Excessive tiredness, lack of sleep little exercise which seriously affects the mental health journey too*
- *I hardly see anyone anymore.*
- *No energy to do anything, sickness and feeling unwell along with exhaustion*
- *No longer able to work due to pain which has a significant financial impact and has resulted in loss of confidence and of self. Socialising has reduced because of pain*
- *Could not undertake my job as a Radiographer due to lack of energy. Likewise, could not perform ususal hobbies (Hill walking, swimming).*
- *Due to immune system being compromised, afraid to go out and mix. Hair loss… horrific. Unpleasant and ugly … did not want to be seen by others*
- *I can't look after my grand daughter for the day (I used to) and she has to go for an extra day in nursery. I can't do my job and I took ill health retirement- I was a headteacher and CEO due to brain fog. Getting bathed showered takes longer - need to rest before getting dressed. When my haemoglobin plummets I am exhausted by simple tasks eg putting on socks. Back ache pain means cooking is difficult - use a perching chair when I can but standing by job is difficult. I need more rest which means less time being with family and fruends.*
- *I was to tired to meet with friends. Family had to make short visits and if they were unwell then had to stay away due to my immunity being low.*
- *leg pain on day 3/4 , sort of fluey feeling day 5 , normal by day 6*
- *I struggled to concentrate and remember things. Even reading was very difficult as I could not understand what I was reading after a few lines. I could not carry on studying for the same reasons. It took me two years to go back to a more decent cognitive level*
- *The first week after chemo was always "written off". After seven days, I was able to slowly pick up things again. I suffered mentally as my house was untidy and I did not get help*
- *I only worked part time during chemo. I chose to reduce contact with friends and family due to the infection risk*
- *During my first round of chemotherapy I took 5 months off sick from work. I have a full time job where focus and concentration is imperative for me to work safely. I did return to full time work for 16months but am currently off sick again whilst on chemotherapy.*

- *Need to stay in bed due to lack of energy. Unable to socialise indoors due to infection risk Trouble with eating due to mouth ulcers, cold sores, pain on eating and digestion issues. Unable to eat many favourite foods due to gas production and bowel problems Have to use specific skin products due to skin sensitivity.*
- *Due to reduced immunity I was unable to mix with family and friends for the whole course. Thus caused significant mental issues on top of the anxiety of the disease itself*
- *Folliculitis was unbearably painful and the prescribed antibiotics further reduced my immune system so I had to shield for significant periods of time between chemo cycles. Very isolating experience.*
- *Needing to isolate due to compromised immune system means not seeing friends or joining in a wealth of Christmas activities such as attending carol concerts or even shopping*
- *I could not work at all and general activities were much restricted at various points in my chemo cycle dependant on energy levels and the need to minimise exposure to potential germs due to compromised immune system.*

Please tell us about any pain or discomfort you experienced as a result of chemotherapy. 91 answers

No bad effect from chemotherapy	*14.29%*
Some effect from chemotherapy	*48.35%*
A significant effect from chemotherapy	*37.36%*

86% of people experienced pain or discomfort as a result of the chemotherapy. The reports range from bone, joint, arms and legs to bowel pain. Some people reported significant pain that has continued and for some it was controllable with medication and eased when treatment ceased, discomfort was rarely mentioned – pain is a more accurate description of the severity. The full set of answers has been included in the accompanying spreadsheet. Here we have included quotes for context.

- *My effects were primarily after the first session and they were horrify . Subsequent treatments gave me fatigue, loss of appetite and abdominal pain and constipation.*
- *Lots of discomfort, and some pain from the following - stomach issues such as bloating, diarrhea, constipation, & mouth ulcers, acid reflux, & mucositis, squashed torso pain, breast to shoulder stabbing pain, & squashed when lying on either side, kidney pain.*
- *Quite severe pain from first set of chemo GI issues also*
- *I suffered from vertigo and fatigue. I felt a loss of control and very depressed. I also developed mouth sores.*
- *Hated the pain*
- *Pain in neck , back , arms , feet . Have to take Omeprazole and painkillers*

- *Joint pain during chemo. I've just got pleral effusion because of my low immune system which is agony.*
- *Back ache - and belly ache managed with paracetamol and sometimes Oramorph.walking and standing are the worst. Must be able to sit down regular. Cooking is problematic- standing at the job. Chopping ingredients etc.*
- *I had severe pain in my feet from peripheral neuropathy which was unbearable despite pain relief My chemo had ti be reduced I still have to take pain relief two years later*
- *Bone pain during week 1 of each round of chemotherapy. Aching knees which continued for approx 6 months following the initial six rounds of chemotherapy.*
- *Need to take Paracetamol and Ibruptofen four times a day. Abdominal pain wakes me up at night.*
- *Some neuropathy which increased over time. I developed superficial thrombophlebitis which was extremely painful in my left hand/wrist.*

Please tell us about any anxiety or depression you experienced as aresult of chemotherapy. 94 responses

No bad effect from chemotherapy	*15.96%*
Some effect from chemotherapy	*57.45%*
A significant effect from chemotherapy	*26.60%*

There was a high % of people reporting anxiety or depression as a result of chemotherapy. For some this related to the side effects of the treatment (e.g. becoming more isolated due to poor mobility/peripheral neuropathy or chemo related fatigue). However, for some the anxiety or depression is due to fears about lack of treatment options at point of platinum resistance. Within many people in our community there is a fear of becoming platinum resistant because there are so few (or no) options at that point. This is an important aspect of our submission – it cannot be overstated how important it is for those diagnosed with ovarian cancer to see that treatments are becoming available at later stages of the disease. Platinum resistance is a key term that we identify on our support line that is more likely to lead to callers expressing suicidal ideation and this is reportedly due to the lack of options at that stage and the fear of undergoing chemotherapy again.

- *Inevitably chemotherapy makes one anxious. Waiting for results between sessions or waiting to hear about a new treatment starting is without doubt one of the hardest things to endure*
- *After the chemotherapy had finished, I had a few occurrences of feeling panicky and anxious about things that were unrelated to my cancer. I had never experienced anything like this before, so believe it is definitely related to my diagnosis.*

- *Low mood which I guess would be like depression. These horrible feelings came out of the blue. I found it took a long time to return to a normal mindset & overcome the feeling of being totally lost. I still have to work hard to stop my mind going down that path again.*
- *Going to hospital caused severe anxiety because my son had died of cancer a few years earlier and I was his carer.*
- *Anxiety around recurrences and life span Very poor outcomes in UK limitations on treatments Fears about the impact on my young children Hard to stay positive*
- *I am terrified that I will lose the use of my legs and fear behind immobile. When I'm well I spend a lot of time outside, particularly working on my allotment.*
- *Too anxious to go out for several days each cycle*
- *Very depressed and anxious.*
- *Anxiety and worry about what treatment maybe available*
- *Terrible anxiety, loss of confidence and self esteem, huge weight gain*
- *I had to go on antidepressants and therapy.*
- *Chemotherapy is a difficult treatment to navigate, and although I suffered from some anxiety followibg treatment my mental health improved.*
- *Felt very low the first week after chemo*
- *Lack of confidence self esteem with hair loss poor had a wig and still do and helps*
- *The effects of chemotherapy really did did depress me I tnought Id bever get through it.*
- *Some depression especially with a come down from the steroids you have to take. But the main anxieties stem from being ill with a serious condition and managing all the appointments, scans (have major scanxiety) tests and navigating the struggling entity that is the nhs*
- *I am worried about the future and get upset when I think about it.*
- *It's a double edged sword : I feel extremely low after chemo but the fear that I cannot continue with it due to my being highly reactive (have been to lots of things throughout my life) is terrifying. I will cope with the low mood to gain the benefit of course The fear always is: if not this drug , then what is available next to me ?*
- *Following the turbulent recovery from neutropenic sepsis after 1st chemo (carboplatin/paclitaxal) there is ongoing anxiety and depression that the same will happen again. Also constant worry that there will be no further options if mirvetuximab is not approved on the nhs - she would be eligible given her folate receptor status. Mirvetuximab could really be a life saver for her but only if approved on the nhs.*
- *As some lines of treatment have not worked well I feel anxious about my future.*
- *Loss of worth loss of confidence reduced social activities makes me low in mood*
- *Feeling very unwell tired and aches makes you depressed as you can't go out and see friends*
- *For me, this was the most significant impact.*
- *Mentally I suffer from anxiety from stage 3 HGSOC as I am platinum resistance.*

- *Felt low when I felt weak Found loosing my hair very difficukt*
- *Major anxiety depression*
- *Suicidal*
- *I was anxious because of the side effects and the restrictions I experienced.*
- *In the days I felt fatigued and nauseous I thought it was awful, and wondered if the treatment was worth feeling bad*
- *I felt alone and scared.*
- *Yo-yo moods due to steroids*
- *Extremely anxious when starting treatment and whilst this did subside I was always anxious about getting infection, doing the 'right' thing, any side effects related to fatigue as you constantly second guess whether you will have enough energy to do something and, if you do, what the impact on you will be if you do choose to go out or do something. Brain fog was also very depressing at times, feeling like you couldn't think straight or function properly and I definitely could not drive more than a very short distance which made me feel quite isolated at times and really impacted my independence. Again, this affects your mental health.*
- *The anxiety around my long term survival*

If you have taken mirvetuximab soravtansine (Elahere) and have platinum resistant ovarian cancer we really want to hear about your experience with this treatment. Please leave your contact details or anything you would like to share below.

- *I had no significant side effects from Elahere. I travelled from Glasgow to London for the treatment and was able to do this every 3 weeks.*
- *Have had three cycles of mirvetuximab so far. 1st cycle severe side effects, including abdominal pain, muscular pain and neuropathy especially in hands. 2nd cycle reduced by 20%. Severity of side effects less but neuropathy still there. 3rd cycle reduced to 70% but neuropathy still there. Continued with mirvetuximab treatment as "good, partial response to treatment" noted on CT scan following 3rd treatment. Ca125 reduced x 10 following treatment.*
- *Haven't yet Gemcarbo seems to be working If gemcarbo stops I will be put on elehere as I've been tested and show positive for what I need to take Elehere*
- *I had my third cycle this week. Still waiting for actual ca 125 numbers but oncologist away at moment. Before the 2nd cycle my numbers had dropped by 2/3rds down over 1000 which is staggering. Whether this is a one off I don't know yet. Side effects - eye issues but these are being carefully managed. Low magnesium seems to have caused a few issues but again currently being sorted.*

- *No not taken it but i would like to be given the opportunity to be considered even having 5 lines of chemotherapy - its not fair that we are always left out especially when platinum resistant, it shouldn't matter the number of lines you've had of chemotherapy as long as you are fit enough to have the drug*

If you have platinum resistant ovarian cancer please share your experiences below.

- *I am BRCA negative and HRD inconclusive. This limits my treatment options. To then find that I was platinum resistant was another blow. I am currently waiting for a start date for Doxorubicin which I will have for 6 cycles so come June/July of 2026 I will be in limbo in terms of treatment options. The chance of Mirvetuximab would take away some of the pressures of the unknown*
- *First became platinum resistant to Carboplatin approx 2 and a half years ago. Had Paclitaxel on its own which was successful but from January to June 2025 was only partially successful. Was put on Caelyx on its own which was only partially successful. There does not seem to be any other drugs left for me to try. The disease is in my immune system , ie lymph nodes and spleen and although the oncology team are keen to keep the disease in the immune system there is nothing left for me to try.*
- *I am frustrated and angry that there are very limited treatment options for platinum resistance ovarian cancer.*
- *NED never achieved throughout chemotherapy treatments. Platinum resistance followed 3rd regime. Mirvetuximab offered and accepted on compassionate access.*
- *I have had 5 rounds of different chemotherapies over 5 years with only short amounts of remission.*
- *Carboplatin stoppped working during the third cycle I have 3 times recuring ovarian cancer. My experience has always been good over the 8 years that I have had ancer, but I know that my options are now significantly reduced, so other non- platinum treatment options would be welcome.*
- *Am waiting to find out if I am platinum resistant*
- *I had further treatment and this has helped but I'm very scared that my future options are so limited*
- *I think elahere should be available in UK I've never had it I've had carboplatin pictaxil which gave me severe allergic reaction I've had parp inhibitors they were great tablets to take at home for my stage 4 my tumors shrank but after a yr my body got immune to them!*
- *I have had PARPi which made me anaemic requiring blood transfusions fatigue and gave me a PE but my cancer returned, I was started on Carbo and Calix which gave me dreadful*

side effects and I only had a partial response. This is demoralising. I was hoping I could use Elehere but to hear it is not available to me is devastating.

- *Treatment options are limited, access to new treatments are not available if you have had more than 3 lots of chemo, the Outlook is bleak*
- *Living with platinum-resistant disease and seeing limited responses comes with intense emotional distress and constant fear.*
- *Feel disheartened as original platinum therapy appears to have become in effective. Further anxiety and stress about where I go from here and is it worth it? .*
- *Being platinum resistant is very frightening and worrying that the options we have are very limited. We need urgently to find treatments that may make a difference to our outcome and have an impact on our mental health too*
- *I have just been told that my cancer is platinum resistant. Another option would be wonderful for me.*

Please share your views on the importance of new treatments for platinum resistant ovarian cancer.

There were 79 answers recorded and we have included some below.

- *Gosh. If my numbers get right down then this Elahere should be allowed on the NHS. Nothing else has worked for me as dramatically as this drug. I have had to travel to London to get this drug, stay in hotels at mighty costs while routine tests carried out which can be very tiring. New drugs give hope, just need a maintenance drug that stops the cancer coming back. Need more miracles*
- *New treatments are vital for ovarian cancer patients with this horrific disease Women have limited treatment options with low response rates and short survival times There is a high unmet need for target therapies. New drugs are vital to provide clinically meaningful improvements without compromising the patient's daily quality of life This is urgent*
- *I was a fit and healthy woman enjoying an active and fulfilling life before starting on this terrifying journey. To know that there is a drug available to women in other countries but not available here in the UK is morally wrong. Of course there are always cost restraints but for women who probably have no other options available to them, this has to be considered an imperative. We should not have to come with a begging bowl, this affects our whole life.*
- *As above, there are no drugs left for me to try or any trials that Iam able to go on because I have had 6 lines of chemotherapy and many trials are restricted to patients who have had 4 lines of treatment only. It is devastating as I've done my best to keep myself fit and optimistic for the last 8 years and would keep on taking chemotherapy to keep my cancer in check if there were drugs available . New treatments and trials are vital to managing this cancer and it's the most horrible feeling to think I may have run out of options.*

- *I feel its important to try new treatments which may reduce cancer growth and extend life expectancy. I don't believe that age or stage of cancer should factor in decision. The possibility for extending a life and improving quality of life is important. Careful management of side effects is essential.*
- *My only option now is eithea trial based on similar science to Elahare or Caeylxwhicg is older science and not tailored to ovarian . I strongly feel there should be other newer treatments available As a result of being platinum resistant, I haven't had any treatment for several months and subsequently have suffered two strokes which has been very difficult my consultant is certain the activecancer is to blame. If I had had another option back in August*
- *Ovarian cancer gives little hope. Most women have recurrences and there have been little or no new treatments in the last ten years. We don't deserve this lack of choice or lack of hope. There is so much research on resistance exercise for aptosis, polyphenols and nutrition, gut health and repurposed medicines but oncologists often seem ignorant or loathe to discuss alternatives leaving us isolated and desperate. It's just not good enough. We are the staple of society. We carry children, we multi task, we care for everyone else, often to the detriment of ourselves, we live with huge stress and elevated cortisol and our immune systems get a battering. It's no wonder they can't fight off this silent and viscous killer cancer. We need more research and we need more hope for better outcomes.*
- *I believe there is a need for more treatment options or for platinum resistant ovarian cancer.*
- *Treatments for platinum resistant ovarian cancer are vitally important to a whole swathe of the female population who are unfortunate to be in this situation. The thought that there may be nomore treatment available to me is a very scary one that will determine how long I can live with advanced cancer.*
- *When diagnosed with cancer there is both a physical and psychological effect. Knowing that the disease is incurable, but treatable means that every available treatment is precious. Each one allows for the hope of longer survival. Perhaps one treatment may last for 12 months and another for 6 months... that's 18 months of life! Knowing that there are a finite number of treatments available means that every treatment that is not suitable, or is denied, reduces the life you have left. It's like fighting a battle against an army that will ultimately overwhelm you. Each treatment is an arrow in your quiver with which you can hold back the advancing hordes. When a treatment is denied, it's like somebody takes an arrow from your quiver and snaps it in half. Now the battle will be lost more quickly. The physical effect is obvious - I will die sooner and the psychological effect is devastating - my hope is taken away.*
- *Without new treatments for platinum resistant ovarian cancer affected patients are looking at a very short remaining lifespan, and hoping that palliative care will make the end of life not too awful. The mechanisms of death from progressive ovarian cancer are not easy ones to bear or to watch.*
- *So important to someone like myself who can no longer be treated with a platinum based drug.*

- *They are very important to me.*
- *New treatments for platinum resistant ovarian cancer give hope to women who have run out of chemotherapy options. Alternative option was to be placed on palliative care.*
- *I cannot stress enough the importance of a new therapy. It will give hope of remission and more time with family.*
- *I'm on second line treatment. I'm platinum sensitive and feel that I've used up two of four possible available treatment. I know that eventually I'll become platinum resistant. I'm HSOC stage 4, HRD+ and BRCA -, therefore the treatments available to me are few. It is vital that new treatments are developed specially for those that are platinum sensitive or resistant.*
- *Need them desperately*
- *I have had five lines of chemo and a mid way scan showed an incomplete response in my current line of chemo. I am worried about being platinum resistant as there seem to be very few treatment options so it seems a pity to not allow Mirvetuxemab*
- *Think it needs to be pushed for . Breast cancer gets lots of publicity ovarian cancer is a silent killer*
- *It's so very important that women are given the best chance to survive this disease the recurrence rates in ovarian cancer are common, research is so important in helping to combat this disease the frigtening thing is more younger women are being diagnosed with Ovarian Cancer theses trial drugs can be a last ditch hope for many women, they should not be denied it if its available.*
- *There are not enough treatments and ovarian cancer is seriously lacking in experts and specialists outside of major cities. To read in your medical notes written by your oncologistthat after 1 recurrence your treatment options are now 'limited and not indefinite' is heart breaking. There appears to be no tailored approach just a set of criteria set previously that dictates what you can and can't have. For example when you ask if secondary surgery is possible or can you have radiotherapy, you are just told no. Without the options of new treatments it feels as though there's no hope and you are just waiting for the inevitable.*
- *There is so little available; I find it difficult to accept that my life is not cost effective when there are no real alternatives*
- *It is so important that everyone is given the chance to live life to the full. As much as they can. If the medical science exists to help women in this dreadful situation, they should be able to access it . It is inhumane to suggest otherwise*
- *These women have a terrible prognosis. As an NHS consultant myself in a different speciality I have now seen the reality of being on the other side of the NHS as a patients relative. And it is brutal - being at the mercy of guidelines and postcode prescribing. Mirvetuximab is a treatment now available over a lot of Europe and the US, we are significantly behind them and this drug could be a lifeline for many women. Please consider the data carefully, which is very positive for improved side effects and survival compared to standard chemo.*
- *Our lives have worth. I have teenage children going through exams. I feel well and am active and yet I have platinum resistant OC. I have much to give and not having access to*

treatment that can extend my life is cruel. Not just to me but my family. This is a killer and without these treatments we are being discarded. There are no effective long term treatments currently, only chemotherapy with its side effects. There are so many options for breast cancer, why is ovarian cancer to receiving the same funding.
My cancer is stage 4 and treatment now is limited, it would mean the world to me and my family if new treatments were available..

- *The treatment for ovarian cancer is hard but always feels worth it if it gives more time with loved ones. I feel all advances which give women more time should be considered worthwhile*
- *I've been told I am out of options and my cancer is growing. Having new treatment would give me hope and more time with my young son. I was 33 at diagnosis because gp wouldn't listen to me whii ohch meant I was diagnosed after it had spread everywhere and at the moment it looks like I won't make 40.*
- *Vital for this to be available*
- *It is vitally important given the late stages we are often diagnosed at. Anyone's cancer can become platinum resistant over time and treatment options should be available to us. Until more effort is made in diagnosing women earlier then funding and research must be put into giving the current cohort of people with ovarian cancer the best chance of a quality of life*
- *MOC affects a lot of women under 40, so the other half of our life is lived with this lingering fear of recurrence and lack of effective chemotherapy*
- *These new and expanding treatments are what keep us going between episodes of treatment, when we become useful contributors to society again, we still lack years behind other cancers such as breast cancer do not pull one of our rugs away! This could provide hope for a lot of patients whose treatment options are limited*
- *Every cancer victim deserves hope and each individual responds differently to treatment. People should not be denied new treatments because of where they live, that's not equality. I myself am a survivor on my 34th year thanks to surgery and modern day medicine. We should be moving forward not restricting these treatments to patients.*
- *It is so hard to balance hope with the reality of limited options and efficacy. Platinum resistant patients need optimism and hope. At the moment there is only emotional overwhelm and fear. It is crucial to expand options to improve outcomes for patients with platinum-resistant disease!*
- *New treatments are absolutely vital for those of us living with platinum-resistant ovarian cancer. Once the standard options stop working, every new therapy means more time, more stability, and a better quality of life. It's not just about treatment — it's about hope, control, and being able to keep living your life. Research really does make a difference!*
- *I felt so lucky to be able to access the full range of treatments. I think that I would struggle emotionally if I thought that my options were limited because of a resistance to the usual front line treatments. Every cancer patient deserves the best treatment available, including new options which have been shown to work.*

- *It's essential, vital ., not just for the physical improvements but for the mental and emotional improvements. It is beyond measure. All cancer patients sore praying for something/ anything that at least gives them hope let alone reduces the horrendous bad effects/ times.*
- *My hope is that ADCs are the new treatment for ovarian cancer. It would be amazing not to have to go through standard chemo and so avoid the terrible mental and physical side effects.*
- *There seems limited options if you are Brac and HRD negative. This drug has brought hope of a longer life well lived.*
- *My oncologist has said I will be put forward for trials after this live if treatment. I am very keen for this of course.*
- *I believe that elahare should be available for platinum resistant patients. Every time I look on N.I.C.E website for drugs like avastin etc it seems like every drug is available for Braca patients or if you have have a mutation or be first line. What about patients whom have had more than 5 lines of chemotherapy no braca gene or mutations it seems we are left out to graze as so to speak - don't our lives matter?? It is very important to us to have some hope its difficult enough living with this disease, as stated it shoudn't matter how many lines of chemotherapy we've had as long as we are well enough to have elahere*
- *Awareness is still low for ovarian cancer and hence most women are diagnosed at a late stage, including myself, so it's crucial that new treatments are available which bring hope to patients and their families. Due to the high recurrence rate associated with ovarian cancer more options need to be available to manage the disease, especially as each patients cancer if different.*
- *Far too many women are dying from lack of options for treatment , we need more and urgently*
- *Very important they might keep me alive*
- *I have only had chemo once but I know in the future i will probably develop resistance I feel it's very important ti have new treatments available so I can have some hope for my future ti try and give myself longer with my husband and family i so want ti see my little grandson grow up*
- *I live in hope that there will be new treatments, if not for me, then for other women in the future. New treatments are critical. This is an awful disease and there need to be options.*
- *We desperately need new alternative treatments which are available to us in other countries. It adds to our mental health burden knowing we get worse care than most other countries.*
- *There are limited options for the treatment of ovarian cancer particularly for platinum resistant patients*
- *For me , I worry that due to being allergic to taxol without elahere as an option if I'm platinum resistant my treatment options are more limited. The side effects from what I have read and heard about from those who have it are more tolerable than chemotherapy. I want to be around for as long as I can, only new treatments can help.*

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- *Currently experiencing first recurrence, I need to know there are other treatments available to me, now and in the future.*
- *It is expected that many of us will become platinum resistant at some point during our treatment. For some people this is very early on when they are feeling fit, well and enjoying a good quality of life. These people should have options available to them and*
- *Invariably most high grade advanced ovarian cancer patients become platinum resistant. Surely those patients deserve the right to have the best evidence-based treatments to deliver the best possible outcomes. Treatkent choices for OC patients in the UK are few, why can't women with ovarian cancer have access to the best? We, the UK are sixth from the bottom in Europe for ovarian cancer survival. Why can't women we not be at the top?*
- *With a disease like this all you have us hope that new treatments will come along. Refusing this new drug for patients takes away this hope and the chance of extended family life which should not be underestimated*
- *I was diagnosed relatively young at age 46, unlike many other patients who tend to be much older - I want to know how much is being down to prolong the lives of younger patients like myself as it feels that there are few options available after first line chemo. I.e., just waiting to die*
- *It is vitally important that new treatments are researched, developed, trialled and AVAILABLE in the UK - all countries equally. We lag behind so many other countries in the world with our treatment for advanced and recurrent OC, especially that which is platinum resistant. Any of us could reach that point at any time during treatment and there has to be other options.*
- *It is vitally important that Elahere becomes available for all those affected to be able to take and give more quality of life and life extension. It is available in other areas of the world and should not be disallowed here*
- *Any new treatment that gives women more options to treat this disease has got to be a great, if not life saving event. Once you become resistant to the drugs designed to save you your options become more limited - to have a new drug come on to the scene for me is great news as I am on my second recurrence and know that options are starting to limit. Please keep the research and the drugs and the funding for women like me and women in the future*

NICE National Institute for Health and Care Excellence

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]

Draft guidance comments form

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	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. The Appraisal Committee is interested in receiving comments on the following: • has all of the relevant evidence been taken into account? • are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence? • are the provisional recommendations sound and a suitable basis for guidance to the NHS? NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that the preliminary recommendations may need changing in order to meet these aims. In particular, please tell us if the preliminary recommendations: • could have a different impact on people protected by the equality legislation than on the wider population, for example by making it more difficult in practice for a specific group to access the technology; • could have any adverse impact on people with a particular disability or disabilities. Please provide any relevant information or data you have regarding such impacts and how they could be avoided or reduced**.**
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Ovarian Cancer Action

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Disclosure Please disclose any funding received from the company bringing the treatment to NICE for evaluation or from any of the comparator treatment companies in the last 12 months. [Relevant companies are listed in the appraisal stakeholder list.] Please state: • the name of the company • the amount • the purpose of funding including whether it related to a product mentioned in the stakeholder list • whether it is ongoing or has ceased.	Abbvie: £10,000 (September 2025) Towards symptoms awareness tool (developed by Ovarian Cancer Action independently) and digital symptoms campaign to encourage earlier diagnosis to run until September 2026.
Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	None
Name of commentator person completing form:	[redacted]

Comment number	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1	We are concerned that this recommendation may imply that ……..
1	Ovarian Cancer Action are passionate about improving the options available for all ovarian cancer patients. In order to make sure our comments on the decision relating to mirvetuximab soravtansine (Elahere) reflect what our community think, we ran an online

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	survey from 25/11/25 to 9/12/25 to gather feedback and evidence from the real people that this decision impacts. We received responses from 93 people. Not every respondent answered every question. Of these, 71 have a diagnosis of ovarian cancer themselves, 10 have lost a friend or family member to ovarian cancer, 14 answered they have a friend or family member who has/had a diagnosis of ovarian cancer, 6 have a high inherited risk of ovarian cancer. Twenty-one responded that they have personally become platinum resistant, and 21 that a friend or loved one has become platinum resistant. Seven respondents answered that they have taken Elahere, and their feedback has been included below. As a general summary: Respondents expressed disappointment at the initial decision not to approve mirvetuximab soravtansine (Elahere) for funding. When asked “Do you think NICE have made the correct decision about Elahere?”, zero respondents answered “Yes”, 14% answered “I don’t know” and 86% answered “No”. Detailed feedback from the survey and qualitative evidence from patient contacts outside the survey, including from our nominated patient expert, have been summarised into relevant categories below.
2	**Chemotherapy and quality of life** One of the questions raised in the assessment of Elahere was the impact of quality of life whilst on chemotherapy compared to Elahere. Six of our survey respondents answered the question “If you have experience of both chemotherapy treatment and Elahere, which do you think offers the better quality of life?”. Of these, five answered “Elahere”, one answered “Chemotherapy”. It is difficult for us to substantially add to the data surrounding this question, due to the small number of patients available in the community who have taken Elahere, but we have been able to gather further qualitative feedback around the impact of chemotherapy on various aspects of quality of life and make some comparisons to Elahere. The lived experiences of ovarian cancer patients and their families make it clear that the chemotherapy received as part of ovarian cancer treatment is associated with a profoundly diminished quality of life. Many describe the treatment as “debilitating,” with side effects that are both physically and mentally overwhelming: *“The ovarian cancer isn’t my adversary in these final months, it is the side effects of chemotherapy with no quality of life*.” The key domains of quality of life were all mentioned in feedback we received about chemotherapy.

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	Self-care/ Ability to maintain daily activities: Patients gave many examples of how chemotherapy negatively impacted their ability to look after themselves and engage in their usual activities. Examples include: "*Days on end in bed, unable to eat or drink or look after yourself. Reliance on others for shopping, cooking, help washing. The physical toll is horrendous and the mental toll that this begins to take can be horrible. To feel so useless and unable to care for yourself or anyone else."* *"I felt poorly and fatigued all the time and could barely tie my shoelaces."* *"I only felt ok during the 2 day period straight after treatment on the steroids. After that I basically felt too ill to do anything."* *"There were points where I couldn't even get up and go to the bathroom."* Mental health: The cumulative impact of chemotherapy is not only physical but also deeply psychological, with patients reporting anxiety, depression, and a sense of hopelessness: *"It is very hard mentally and physically to know I'm putting my life on hold for this chemotherapy regime and that I'm very likely going to have to again."* *"My mental health was suffering and I cried most days. My husband looked after me and basically did everything for me. It was the hardest thing I've ever done. The treatment itself I found really difficult I cried from the moment I set foot in hospital till I left. I became scared of everything."* *"My life revolves around medical appointments and procedures. It is very hard to plan for the future and as we come up to Christmas it looks like this year will be lonely and isolated."* Pain: We had feedback that chemotherapy resulted in pain: "*Initially I was OK whilst on chemo but it has a cumulative effect and so did suffer from chronic joint pain, neuropathy and fatigue."* *"I learnt from having chemotherapy twice, the things I learnt were side effects like aches in your joints, tiredness increase in duration with each round, in the last two rounds I slept a lot, after the last session all day, waking to eat and going back to bed. Treatment is like a rollercoaster, the feeling well shortens between sessions."* *"I experienced extremely painful legs which made it difficult to walk. Generally felt very unwell. I stayed at home for 6 months and didn't want to see anyone."*

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	"Traditional chemo is so hard to withstand physically and mentally. The pain of bone aches, then taking medication to relieve those aches, the nausea and taking medication for the nausea, sleepless nights, then taking medication for that and the list goes on." *"My mother received chemo for ovarian cancer, it took a full day to be given and then a couple of days later the immediate side effects kicked in. She would throw up and cry in pain. Months after chemo finished she had issues with bones and the consultant said the chemo had effected her hip bones so the point she needed a hip replacement and was in agony every day, she died before she got a hip replacement."* Mobility: Combined with the pain issues stated above, patients can also experience specific mobility issues: "*The Chemotherapy my mum was given has resulted in peripheral neuropathy. She has terrible pain in hands and feet and can no longer walk independently."* Feedback tells us that chemotherapy gets harder with each recurrence. Note that for the target population, they are in the situation of having been through chemotherapy before so the side effects may have built up over time: *"Currently on my third lot of chemo and quality of life is very different to when I went through frontline treatment. It's hard!"*
3	**Capacity for patients to continue to contribute to society and community** The population of women who are going through treatment for ovarian cancer have a great deal to offer society and their community and their quality of life on treatment therefore impacts far beyond their day to day: *"Generally, women like me with ovarian cancer are from an age group that are central to their families and society in general. I help out with my grandchildren, support my older husband, offer my services in the local community and contribute in so many other ways to society. I am 69 years old, fit, otherwise healthy and have so much to offer. Please don't take away my future."* *"I am an NHS Midwife and a mother to a 7 year old little girl. Taking away future options for me is losing an experienced midwife, losing a mother, destroying a family."* The value of a drug not only should be measured in terms of cost of the drug and months of life added, but the wider value of these lives to society and the community.
4	**Impact of chemotherapy on family members:** We must remember that the impact of any treatment goes beyond the patient, and extends to family, friends and all caring for them. The impact of chemotherapy and the potential benefit of Elahere must also be considered in this respect: *"I was lucky to have a supportive family, as I don't drive they took me to all my appointments. Family helped with cooking, shopping and housework when I was unable to do it."*

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	"You need family or friends to take you to treatments. I was having chemo for 6 months, the last 16 sessions being weekly. This is time consuming and tiring for everyone. My husband is a contractor, he had to take time off unpaid to take me. This adds financial pressure to the burden. Once chemo finishes you then have to recover, this takes months. Chemo is a really tough necessary evil, it's not nice." *"I'm 30 - and my mother was diagnosed with HGSOC at 67, last year. Life on chemotherapy was pretty grim for her - and me. I took time off work to support her - during a period of 8 months when she had very poor quality of life. She had struggles eating, struggled to sleep and overall felt pretty awful. It was really sad - and also impacted me significantly from a work perspective."* *"It's utterly terrifying especially when you have a young family, my husband has all the financial and emotional pressure as I am unable to work currently."* Quality of life of all the family should be taken into consideration when comparing treatments.
5	**Quality of Life on Elahere Is Good** In our survey, we heard from 7 people who have taken Elahere. We also had information from our nominated patient expert who has experienced treatment with both chemotherapy and Elahere. We appreciate these data are limited, however they are the most valuable in representing the situation that these women find themselves in. In contrast to chemotherapy, patients who have accessed Elahere (mirvetuximab soravtansine) reported a **significantly improved quality of life, with fewer side effects and a return to normal activities.** Patients tell us that Elahere allows them practically to continue their previous lifestyle to a greater extent than chemotherapy. They tell us that the three-weekly cycles are more manageable than the potential alternative of weekly Taxol treatment. Patients tell us that overall Elahere's more manageable side effects result in an easier return to normal life, and that includes allowing them to ability to maintain relationships and socialise which helps maintain their mental health. One patient told us that Elahere had had a positive impact on her cancer, and *"I walked out of the consulting room with the biggest smile on my face since the beginning of this horrid cancer journey."* Another stated "*I have found that I don't have the foggy awful feeling while receiving Elahere. I'm not lethargic, not nauseous, my brain feels clear, and I have found my recovery time between treatments is so much quicker, giving me 2 weeks out of 3 of feeling like myself and wanting to get out and do things vs the traditional chemo it was the reverse, 2 weeks of feeling not like yourself and maybe 1 week of 'normal'."*

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	Others tell us: *"After finishing my last chemo I knew that I was running out of options for treatment. I'm Canadian, so Elahere was in the process of being approved for use in Canada. This drug is one of my last treatment options. What a life saver that it got approved in the nick of time before I started another chemotherapy as I'd then be unable to receive Elahere."* *"Mentally I feel like there is such hope to be on Elahere!"* *"I'm lucky and taking Elahere, I work full time, I socialize, dine out and have the best quality of life I could wish for no cancelling engagements or calling in sick due to the side effects of other chemotherapy drugs."* *"My mental health has been boosted via positive CT and CA results. I feel as if I have been given precious extra time to spend with my children and grandchildren. I do not feel a burden to loved ones as I'm physically self sufficient."* The impact of quality of life on Elahere being better than on chemotherapy translates into patients who are more able to contribute to their community and continue to work, and also allows their support system to do the same. *"As someone working age, being able to keep my mother in a healthy position for longer, when she does not require my care , also keeps me continuing as part of the workforce."* As you can see, in the domains of self-care, ability to maintain daily activities, pain, mobility and mental health, we have feedback that Elahere provides higher levels of quality of life than chemotherapy.
6	**Quality of life on chemotherapy resulting in patients choosing end of life** Multiple patients have expressed to us that they found chemotherapy so tough, that were their disease to return, they would choose not to have any treatment at all rather than go through that experience again. *"For me personally after the initial diagnosis and first lot of treatment I thought there is just no way I can do that again. Chemotherapy is so tough. You have the trauma of knowing it is most likely coming back."* *"I felt that the system was designed to assume that I have OC and I'll be ill for a short period of time and then I'll die from it, so there's no point investing any time or energy into any recovery or quality of life. It felt that I was forgotten about as there just wasn't anything in place to support me. I've heard similar comments from members of the OC patient community where it is felt that OC is not seen as a priority with a feeling of just being sent away to die."* For patients in this situation, removing the option of Elahere means their inability to face chemotherapy again is a decision to remove treatment and face the end of their lives. The comparator is therefore death, and not chemotherapy

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7	**Unmet need for treatment options** The scarcity of effective options for women with ovarian cancer, especially those who become platinum-resistant, creates a climate of fear and despair even before they reach recurrence: *"There just aren't enough treatment options for women with OC, particularly when a recurrence happens."* *"Ovarian cancer needs more options. Options give us hope and hope is the only thing that makes it possible to keep going."* Patients and their families repeatedly express the urgent need for alternatives to chemotherapy, emphasizing that hope and time are invaluable: *"Having more treatment options available is vital. Mirvetuximab soravtansine offers hope, and for many women has proven to be very effective. It offers the prospect of living with and managing a chronic disease, as opposed to dying from a terminal illness."* *"The chance of this disease recurring is so high and so the more options available to women if they become platinum resistant the better."* We believe women in this situation need options available and that includes Elahere.
8	**Impact on the disease** When we are considering the impact of a drug on a disease like ovarian cancer, we must consider the purpose. In the situation of a woman with advanced ovarian cancer, who may have been through multiple rounds of brutal treatment only for the disease to return again and again, they are not hoping for a miracle cure. They are hoping for a few more months, to organise their affairs, to take a last trip without all the debilitating effects of a chemotherapy that will not save their life. They are looking to attend their loved one's wedding, or have a last Christmas. This must shift the dial in calculating the impact of funding the drug. We acknowledge that the goal of Elahere isn't to guarantee no further future progression. However, it's important to consider the impact of a period of time on Elahere compared to chemotherapy on the health of the patient for future recurrences. Based on the feedback we have had, for a woman who takes Elahere and later relapses, her physical and mental health, may be better when she comes to face another round of chemotherapy, compared to if she had had chemotherapy in the intervening time. This may result in greater quality of life at future recurrences.
9	**Experiences of platinum resistance** As well as comparing quality of life on Elahere to quality of life on chemotherapy, it's important to take into account the quality of life generally for women who are platinum resistant, and their families. Feedback from patients tells us this is a horrific position to be in: "*Having platinum resistant ovarian cancer and being told there are no more treatment options available to you is terrifying. Living with that fear and uncertainty can take over*

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	your whole life. The lack of treatment options for women in this situation meaning living with the constant and real prospect of death hanging over you at all times. And the toll that takes on you mentally is overwhelmingly huge. It makes it impossible to try and plan and live your life as no one can predict how long you have left as there as so few treatment options and so little knowledge about how long they may work." *"It is so demoralising that the intensity of the chemo program has given minimal benefit. To maintain hope other options must be available so there is so thing that can be done."* *"All our plans for the future and for when we retire are very uncertain. We no longer have a social life, we have to decline invitations to meals, parties and if we do see anyone we have to make sure they are fit and healthy. It is all very isolating and can be very lonely."* *"Finding out that your body has again betrayed you is so sad and overwhelming. Knowing there is a limit to the treatments available is depressing. It's difficult to tell your loved ones that your time is running out. A panic sets in as to what do we do in my time left, how do my loved ones cope once I'm gone, how does my spouse make it on his own with only one income. The fear that sets in is debilitating."* *"Psychologically it's difficult as it feels like the end of the road and I don't want to die."* *"It is hell. My body is resisting the drugs that originally saved me."* *"It is devastating and I am back to square one after 7 years of constant treatment regimes. It's hard to not think of the end every day."* *"I'm now 49 and have no idea how long I'll be around. The dreams and future I had planned with my husband are gone. I feel totally lost, in limbo waiting for the terrifying rollercoaster to start again. We can never totally relax, we can't plan anything too far in advance, every blood test is filled with anxiety and dread."* *"I feel totally vulnerable knowing it's highly likely to reoccur again and I'm a ticking time bomb."* There is a huge mental health impact on women and their families, knowing their options are limited should they become platinum resistant: *"I am already aware that treatments are limited in general for woman with ovarian cancer and the fear of becoming chemo resistant is already on my radar having heard many stories on hearing stories of others forced to take weekly chemo regiments as their last options...or in some cases no options."* Women are in the position of having to consider what quality of life they would accept in order to have some extra time: *"Anything that gives a better quality of life and a little more time should be available."*

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	"Most of the women I know would still opt for the trial route when exhausted standard of care treatments in order to hang on to their lives a little longer." "*My mum died 11 months after diagnosis at the age of 62 having tried all treatment avenues available to her. If there was a drug that could have helped she would have tried because she wasn't ready to leave us."* *"We have worthwhile lives to live and want to do whatever we can to stay alive to see children grow up, achieve our goals and contribute to society."* Women who are currently in the position of needing Elahere told us: *"I have become resistant to my chemotherapy and this drug was my final hope which has now been taken away from me. I shall now probably die thanks to this decision."* *"I am on my last treatment option for stage 3C OC. Weekly palliative Paclitaxel chemotherapy for the last 7 months, 30 infusions and minimal quality of life. My only hope to improve what remaining time I have left with an outside chance of some disease reduction is ELAHERE. Without it I am now looking at end of life care instead of renewed optimism that I can keep fighting with this disease."* One patient sent detailed feedback about her experience with recurrence, platinum resistance and weekly chemo: "*I was diagnosed in March 2019, 2019 Stage 4a HGSOC. After multiple recurrences, since March 2025 I've been on weekly Paclitaxel. They are clearly cumulative on the system. I've had so much 3 weekly chemo over the last 6 years and managed to bounce back within a day or so. Used to head off skiing, on a river cruise or enjoy time being at home. Now during the 3-4 recovery days* ***I'm a husk of the independent woman I was***. *At least 1 day I sleep completely through sometimes 36 hours, only waking for a pee. Once that initial sleepiness passes it's carry on resting, the batteries are so low. Come day 4 and 5 I'm able to potter about the house. I've always been upbeat even during treatments, had energy and willpower to do whatever I would normally do. Now even a planned treat one day or two before next chemo I find it an effort to get dressed up, try and feel normal. Not had neuropathy before but sensation has definitely changed and it's starting in my toes now. Consensus is it's the build of chemo. That seems to have been the final straw and I am having weepy days. I can cope with the permanent hair loss, lymphoedema, depleted mobility and lethargy, but no end in sight is the hardest. I think that just about sums up palliative chemo. I opted in August to start privately funded Avastin to support the Paclitaxel. I'm in limbo. It's treadmill that's going nowhere. Nothing else is available if I come off the Paclitaxel but it's no life when 4 out of 7 days I'm off grid. My hope was that IF my original tumour tested positive a 3-weekly regime of Elahere might give me some respite AND have better chance of targeting and reducing OC in the lymphs.* *Now after the NICE decision last month my only alternative is to go back to my private oncologist, get tested and if positive see how much it will cost to self-fund Elahere myself. Already costing me £3200 every 3 weeks for Avastin, using up existing savings and my*

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]

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	private pension lump sum but I've got to keep trying till the money runs out or I'm truly terminal. For now I've still got to hope there's more time." These women and their families are at the stage of exhausting all options and hoping for a few more months with reasonable quality of life, which Elahere can offer them.
10	Potential to reach other treatments Another aspect to consider when judging the effectiveness of the drug, is that any additional months of life may be a bridge to another treatment option. Keeping a woman alive or giving a treatment that allows better quality of life may allow the family to search for suitable trial options, or for other drugs to become available: "*I was supposed to die seven years ago, when I was just 24 years old. There were no known treatment options available to me. My oncologist pushed for me to have access to a treatment that they weren't sure if it would work or how effective it would be. It worked- it gave me 2 years. Then we found another one, that gave me 4. Now I'm on my third line of treatment that no one would have expected to work for me all those years ago and I've had 7 whole years. Almost another third of my life from when I was diagnosed. From when I was told that I was to die. Please don't take those years away from other women. Please give them the chance. The chance to try. The chance to hope for more time and to change the narrative they've been given. I've lived such a beautiful life since that day. You can't put a price on that. It is worth everything to me and the people around me. We would all do anything for more time. Please don't take that away from us*." Allowing women in this position to have access to Elahere may give them additional time in which to find other trial options, or for other treatments to become available. For example, pembrolizumab is being assessed by NICE in 2026 for women with recurrent platinum resistant advanced ovarian cancer.
11	Equality considerations: Living rurally is considered a health inequality, because of the impact on patients of barriers such as greater travel distance and isolation. Patients in rural settings have explained to us many times how being far from a major centre impacts their treatment and quality of life. *"Living in a more rural location, I had to travel into hospital to have my treatment. This meant long car journeys to get to my chemotherapy on a Tuesday, and once a month on a Wednesday too to meet with my oncologist. This was tiring for me but also for my support system who drove me and waited while I had my treatment."* *"I live in a rural setting, and after misdiagnosis and problems with locally, I decided to transfer my treatment to the Christie. Every month I drive 140 miles there because I have to feel confident in my treatment."* This travel relies on being wealthy in terms of money, time and support system.

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	For a patient with platinum resistant ovarian cancer, if their recurrence means their only option is weekly chemotherapy for the foreseeable future, this can have a significant impact on their physical and mental health, finances, support system's mental health, and the ability of both themselves and their support system maintaining employment. Elahere offering these patients a three-weekly infusion, with greater quality of life in between treatments compared to chemotherapy, would allow rural patients to have less stress in their lives, and in the lives of their support system who help to take them to appointments. This logic applies equally to those in deprived areas, who would struggle with time off or travel time/expense regardless of their location in relation to a hospital.
12	Our nominated patient's view: Ovarian Cancer Action nominated a patient representative who was unable to attend the committee meeting on the day but submitted her views to NICE in advance. Her submission was detailed and she has nothing further to add in addition to her previous statement, however we would like to emphasise the following points made by this patient expert which relates to the questions raised here: • When receiving chemotherapy treatment, they experienced a severe negative impact to their quality of life. They worked full time and often had to call in sick. They lost their senses of taste and smell and experienced a low appetite as a result. They lost their hair which made them feel miserable and very isolated. They said that they felt very low. • Preparing for the next cycle of chemotherapy felt debilitating because it meant anticipating the negative experience they would inevitably have. • They have experienced a significant positive difference in how they feel in themself with mirvetuximab compared with chemotherapy. • They have not experienced any side effects and are now able to live a relatively normal life. • In addition to not experiencing any side effects with mirvetuximab, they feel much less depressed and anxious. • The side effects of chemotherapy had such a negative impact on their quality of life that if they had been offered chemotherapy again instead of mirvetuximab, they would have questioned whether to continue with treatment. In our nominated patient's view is summarised by their quote below: *"Elahere has taken my fear of facing weekly chemo - three weekly cycles are manageable and allow me to work full time, as I'm single and have a mortgage to pay, and that's the biggest financial worry I have. Elahere has given me a boost in confidence. I truly hope that many more women will be able to receive this lifeline and get to enjoy life*."

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13	**Conclusion** The decision not to fund Elahere leaves women with ovarian cancer facing a future with few options, diminished hope, and a significantly reduced quality of life as their only option may be draining weekly chemotherapy, or no treatment at all. The testimonies above demonstrate the urgent need for new treatments and the transformative impact that access to Elahere can have on patients' lives. *"Ovarian cancer needs more options. Imagine being 24 and being told there were no treatment options available to you. You would give anything to have more time, try anything to be given a chance to live a little longer and stay and spend more time with the people you love. It's not fair to take that chance away from people. You cannot put a price on that time."* *"Elahere offers women like me with ovarian cancer a chance at having more precious time with family and without the side effects of chemotherapy the treatment could be much kinder to my immune system meaning I don't have to hide away and isolate*."

Insert extra rows as needed

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- Do not use abbreviations.
- Do not include attachments such as research articles, letters or leaflets. For copyright reasons, we will have to return comments forms that have attachments without reading them. You can resubmit your comments form without attachments, it must send it by the deadline.
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Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Target Ovarian Cancer
Disclosure Please disclose any funding received from the company bringing the treatment to NICE for evaluation or from any of the comparator treatment companies in the last 12 months. [Relevant companies are listed in the appraisal stakeholder list.]	AbbVie April 2025 £10,000 to support of online digital events, support services

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Please state: • the name of the company • the amount • the purpose of funding including whether it related to a product mentioned in the stakeholder list • whether it is ongoing or has ceased.	
Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	None
Name of commentator person completing form:	[redacted]

Comment number	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1	We are concerned that this recommendation may imply that ……..
1	We are concerned that this recommendation does not fully consider the impact that chemotherapy can have on quality of life. Target Ovarian Cancer has recently surveyed patients with ovarian cancer in our community on the effect chemotherapy had on them. We found the following: • 58 per cent reported some problems with mobility • 44 per cent reported some problems with self-care • 69 per cent reported some problems, and 15 per cent reported extreme problems with undertaking their usual activities • 81 per cent reported some pain and discomfort and 4 per cent reported extreme problems with pain and discomfort • 65 per cent reported some problems with anxiety and depression and 12 per cent reported extreme problems with anxiety and depression.

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	Patients with ovarian cancer also shared their experience of chemotherapy in their own words: *'Chemotherapy takes away your life, it's very debilitating and impacts heavily on social activities, they say go and enjoy life but that becomes increasingly more difficult with the more chemo you have, you're very vulnerable with no immunity.'* *'Weekly chemotherapy for months on end has diminished my quality of life to a treadmill of treatment, sleep to recover, fatigue and 2-3 days of normality before the cycle starts again.'* It was not possible with the responses we received to produce a comparator dataset on quality of life for those that had taken mirvetuximab soravtansine but what is clear is that chemotherapy treatments for ovarian cancer have a significant impact on quality of life and this must not be underestimated when comparing it to emerging treatment options.
2	We are concerned that the recommendation does not consider the impact that new treatment options can have in quality of life, particularly on emotional wellbeing Patients we surveyed told us about how knowing that they are running out of treatment options when they became platinum resistant impacts their quality of life *'Now I am platinum resistant, my treatment options are getting fewer and fewer but I am not ready to give up and die quietly while I have a reasonable quality of life and feel I can still contribute to my family and community.'* *'It was disappointing to know that my ovarian cancer had become resistant to platinum as it all of a sudden narrows my treatment options which is frightening as I am someone who wants to be able to continue living as long as I can'* *'I am platinum resistant and getting to the end of alternative chemotherapy options, so any treatments are of interest to me to extend my life and maintain the quality.;* *'This drug is vastly important to ovarian cancer survivors as we know there isn't a lot out there for us to have especially when you become platinum resistant,'*
3	We are concerned that this recommendation does not account for the level of unmet need in platinum resistant disease. Repeated chemotherapy cycles can lead to a significant impact on quality of life as outlined in point 1 and the current treatment options are limited in effectiveness. It is vital that patients with platinum resistant disease are able to access treatments that may extend their lives.
4	
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Insert extra rows as needed

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Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	British Gynaecological Cancer Society - Prof Agnieszka Michael

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Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	N/A
Name of commentator person completing form:	Agnieszka Michael

Comment number	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1	We are concerned that this recommendation may imply that ……..
1	We are concerned that the uncertainties stated in the document that led to the proposed response have not been fully evaluated. The first point raised was about the health-related

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	quality of life (QOL) and how it differs for people having mirvetuximab soravtansine and people having chemotherapy. From the perspective of an experienced clinician the study provides ample evidence that the quality of life for patients on chemotherapy for platinum resistant ovarian cancer (OvCa) is very poor and the Mirvetuximab patients had a better QOL. This group of patients have multiple symptoms and the response rate to chemotherapy is low (less than 50%) and short-lasting (max 6-8 months benefit). As outlined in the study , mirvetuximab is the first drug that shows an improvement of QOL for this group of patients and the rate of response Is also much higher. We therefore strongly encourage the committee to reconsider the evidence examining the QOL for this group of patients as from the clinical perspective there is no doubt that Mirvetuxiamb is effective in this setting. Although the overall magnitude of benefit did not reach statistical significance in response rate , there is still a substantial benefit for this disadvantaged group of women. We agree that the committee has taken all the relevant evidence into account , however the benefit in terms of response rate and QOL for women with platinum resistant ovarian cancer has been underestimated
2	We also want to comment on the point relating to “how long people live after having mirvetuximab and after having chemotherapy for platinum resistant OvCa . We know that after the onset of platinum resistance the length of live for women is in the range of 9-12 months (IGJ Foote et al vol 28 (2) 302-307; 2018). Women treated with mirvetuximab have a survival advantage of approximately 6 months. We can therefore speculate that this group of women , if treated with mirvetuximab can survive to about 18months , maximum 24 months . This needs to be taken into account in the economic model as the time on treatment with mirvetuximab will be limited
3	The uncertainty regarding “the average age of people starting treatment” is very easy to answer. We now have the data from the National Audit , running for 2 years (NOCA) and prior to that Ovarian Cancer Audit Feasibility Pilot study

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	(BGCS-council-agm-july-2020-NCRAS-OCAFP-report.pdf). There are data tables on the NOCA website that are current and the average age of patients diagnosed with ovarian cancer is 66.3 y.o . Platinum resistant disease develops with 12-24 months from diagnosis. This figure should be taken into account in the economic model
4	As BGCS we feel that the provisional recommendations should be reconsidered and the economic model checked to address the relatively short time that women with platinum-resistant OvCa have and as a consequence, limited period of therapy for Mirvetuximab.
5	
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Insert extra rows as needed

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Single Technology Appraisal

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]

Comments on the draft guidance received through the NICE website

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

Yes.

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

As discussed in my comments, there is uncertainty regarding the overall survival projections utilised in the analysis and the sensitivity of the HRQOL tools used.

Are the recommendations sound and a suitable basis for guidance to the NHS?

Mirvetuximab provides a step-change in the management of platinum-resistant ovarian cancer. It is a biomarker-selected therapy with a novel mode of action. It is the first drug to demonstrate a clinically significant survival advantage over standard-of-care treatments in platinum-resistant ovarian cancer with improved tolerability.
It is important that this drug is available as an option for ovarian cancer patients with platinum-resistant disease who gain very limited benefit from current standard chemotherapy options.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

No.

Mirvetuximab provides a step-change in the management of platinum-resistant ovarian cancer. It is a biomarker-selected therapy with a novel mode of action. It is the first drug to demonstrate a clinically significant survival advantage over standard-of-care treatments in platinum-resistant ovarian cancer. The 4 months improvement in median OS is extremely

meaningful to patients with the disease. It is associated with a substantially higher response rate than standard chemotherapy (43% compared to 16%) which will be associated with a greater reduction in cancer-related symptom burden. It also has a more tolerable side-effect profile than standard chemotherapy meaning that more patients can remain on treatment. Although ocular side-effects are seen with mirvetuximab, these are generally mild and reversible and can be mitigated by rigorous use of lubricating eyedrops.
It is important that this drug is available as an option for ovarian cancer patients with platinum-resistant disease who gain very limited benefit from current standard chemotherapy options.

I am providing these comments on behalf of myself and my consultant colleagues within the Gynaecological Medical Oncology service at The Christie NHS Foundation Trust.

Mirvetuximab is the first drug to demonstrate a clinically significant survival advantage over standard-of-care treatments in platinum-resistant ovarian cancer. The 4 months improvement in median OS is extremely meaningful to patients with the disease. Although it is very difficult to provide long-term survival projections, it is noteworthy that at 2 years 12% more patients who received mirvetuximab in MIRASOL were alive than who received standard-of-care (34% vs 22%). A cross-trial exploratory analysis of patients receiving mirvetuxmab for platinum-resistant ovarian cancer (O'Malley et al ASCO 2024) reported that of the 34% of patients considered long-term survivors (classified as >15months), 40% were still alive at 30 months. This alongside the positive PFS2 data from MIRASOL (Moore et al ESMO 2025) indicates that a minority of patients receiving mirvetuximab live several years. This suggests that the EAG estimate of 5 year survival may be pessimistic.

Patients with platinum-resistant ovarian cancer have a significant symptom burden which impacts negatively on quality-of-life. However, the EORTC QLQ-C30 may not be the most sensitive tool to detect and monitor this. In a large prospective study of patients with platinum-resistant ovarian cancer (using a novel validated MOST symptom questionnaire) 55% reported moderate to severe abdominal symptoms and 87% an impaired HRQoL at baseline (assessed using EORTC-QLQc30). 40% of patients reported an improvement in abdominal symptoms with standard chemotherapy but only 20% had an increase in HRQoL (Chen et al Int J Gynecol Cancer 2022). Symptom burden, in particular abdominal symptoms will be alleviated more effectively by treatments with a higher response rate such as mirvetuximab (43% compared to 16% with standard chemotherapy in MIRASOL). Mirvetuximab is also associated with a lower toxicity burden than standard chemotherapy as reflected by lower discontinuation rates due to toxicity (9% vs 16%) in MIRASOL indicating that adverse reactions are less likely to impact on patient's HRQoL

Name	[redacted]

Comments on the DG:

Has all of the relevant evidence been taken into account?

There has been insufficient weighing of evidence of benefit of Mirvetuximab. The committee acknowledge that they may have underestimated the symptomatic benefit of Mirvetuximab in their assessment which is crucial in patients with platinum resistant disease and limited options that can result in disease shrinkage and alleviation of symptoms.

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

These summaries do fail to take into account full clinical effectiveness data in terms of symptomatic benefit, and the need for abraxane use in many patients with PROC.

Are the recommendations sound and a suitable basis for guidance to the NHS?

"These recommendations are unsuitable deny a group of patients with high unmet need (patients with platinum resistant ovary cancer) an additional line of effective therapy. Not only did the Mirasol trial demonstrate a clinically meaningful OS benefit of around 4 months but the high response rate (42.3% vs 15.9%) is hugely impactful for patients with with organ threatening disease (e.g. impending bowel obstruction or ureteric obstruction) or those with painful peritoneal or liver deposits.

The committee assessment ignores that there are a substantial group of patients who develop severe peripheral neuropathy following initial taxane, making them ineligible for paclitaxel which is usually first choice as the most effective first line following platinum resistance. In my experience this occurs more often in those with other conditions that can cause neuropathy e.g. diabetes and therefore the failure to approve Mirvetuximab adversely impacts those with these conditions, and in particular black and ethnic minority populations who are more at risk of type 2 diabetes, as well as those with comorbid mental health conditions taking antipsychotics who are also more at risk of type 2 diabetes due to metabolic side effects. These two groups make up a substantial proportion of patients within my practice at Barts Health and are individuals less likely to be included in trials so the full benefit for them may not have been seen. Any cost estimates should take into account that those patients with severe neuropathy or other adverse reactions to taxane would therefore go onto Abraxane which is more expensive."

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

As mentioned above, many patients who are black or ethnic minority, are at increased risk of type 2 diabetes and therefore more likely to develop peripheral neuropathy which precludes paclitaxel use. This guidance denies patients with platinum resistant ovary cancer a vital alternative line of therapy in Mirvetuximab, as paclitaxel, the usual first choice may be contraindicated in these patients.

Name	[redacted]
Comments on the DG:	

Quality of life on chemotherapy in the context of platinum resistant ovarian cancer is poor. Treatment breaks are very short, response rates poor and toxicity burden is high.
In my experience, patients on Mirvetuximab in this setting however, have a better quality of life with far fewer side effects and a higher chance of treatment benefit.

The 5 year survival rate of a patient with platinum resistant high grade ovarian cancer treated with chemotherapy is 0. No exceptions.
Most patients survive less than 1 year in this context.
If the 5 year survival following treatment with mirvetuximab (10%) means that 1 woman in 10 with platinum resistant disease survives significantly longer, that is extremely meaningful.

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

No. I feel it is unjust to make a decision based on date not yet available such as long term survival as it does not yet exist.

Are the recommendations sound and a suitable basis for guidance to the NHS?

No. With regard to point 3.9 - long term survival. For many years with no alternative to chemotherapy when platinum resistant survival has been poor. To have an alternative is one of the most exciting and hopeful new break throughs to come into clinic. These patients deserve hope and to access new drugs to enable them longevity with a good QOL. I appreciate the long term data is not currently available but this drug could potentially change the landscape for the patients and therefore should be considered as a treatment option with the patient at the centre of the decision making.
With regard to point 3.10 QOL. Patients tend to become symptomatically unwell when platinum resistant., If they have had many lines of chemotherapy they also have issues with bone marrow recovery and electrolyte management. To offer a new drug that may reduce some of these issues is incredibly positive to allow them good QOL to allow them to

live as they wish and hopefully reduce time needed in hospital for supportive treatment as well an admission for symptom management. With poor prognosis this is so vitally important to be acknowledged.

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

Yes.

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

It is important to note that MIRASOL demonstrated a statistically significant improvement in both PFS and OS in a group of patients with poor prognosis where improvements in OS are notoriously difficult to achieve. It is also important to note that there are no approved novel therapies in platinum-resistant ovarian cancer - patients treated in the NHS have only conventional chemotherapy as treatment options. Mirvetuximab has the potential to be the first molecularly-targeted therapy for these patients.

Patients with platinum-resistant ovarian cancer are unwell with high symptom burden and generally poor quality of life. Median OS in routine practice is frequently lower than that achieved in the control arm of the MIRASOL trial, which, as the committee noted, recruited patients who are younger than routine care patients in the NHS. As the committee noted, phase III trials frequently recruit patients who are younger and of better performance status than in routine care.

There are statements that I do not think are justified:
Section 3.7: "(The committee) concluded that mirvetuximab may be more clinically effective in people with a primary platinum-free interval of more than 6 months." In the MIRASOL trial, the 95% confidence intervals for hazard ratio for both PFS and OS for the <6 month and >6 months primary platinum interval overlap. Thus, one cannot conclude that there is a difference in effectiveness according to primary platinum-free interval and the committee have over-interpreted data.
Section 3.9: Clearly, modelling long-term OS for a novel therapy is challenging and I understand the arguments for and against different , given trial data that only extend for a few years. However, I agree with the clinical experts that it is plausible for a small number mirvetuximab-treated patients to remain alive at 5 and even 10 years given that 5.3% of patients in the mirvetuximab arm of MIRASOL had a complete response to treatment, compared to 0% in the control arm. Thus, an assumption that all patients on mirvetuximab will be dead at 10 years does not seem justified.
Section 3.17: Severity. The committee applied a severity rating of 1.2. However, I believe that platinum-resistant ovarian cancer should merit a rating of 1.7 given that patients in NHS routine care will be older and with greater symptom burden than those enrolled in the MIRASOL study.

Are the recommendations sound and a suitable basis for guidance to the NHS?

Yes.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

No.

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

No - I dusagree with the assertion of no vial sharing for mirvetuximab. Due to doseage being nased on weight there are greater opportunties to vial share. It is also very rare that you will only have one patient on every occasion. There will be occasions when there will be multiple pts. Therefore although it will not reach the leavels of 50%, vial sharing of 10-15% is more than achievable

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

No since vial sharing has been discounted

Are the recommendations sound and a suitable basis for guidance to the NHS?

No - since based on cost-effectiveness estimates which do not factor in vial sharing

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

N/A

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

Platinum resistant ovarian cancer (PROC) is the most difficult phase of the disease to treat. The activity of current treatments is low, with at best a short-term improvement in symptoms for a few months and expected survival of 12 months. These data from various trials probably over-estimate the benefit compared with non-trial population of patients in England and Wales. This phase of the disease is characterised by multiple symptoms and frequent hospital visits and in-patient episodes due to disease-related symptoms.
Mirvetuximab soravtansine is the first precision-led treatment for platinum-resistant recurrent ovarian cancer, meaning that it is benefit applicable only to a selected population. The MIRASOL trial with mirvetuximab soravtansine was also the first trial to show a significant improvement in both progression-free and overall survival in this population with higher tumour response rates leading to better earlier symptom control than with standard chemotherapy. The availability of this treatment would be the first opportunity to apply a precision-led treatment to a selected subgroup of people with platinum-resistant ovarian cancer, offering an improvement in outcome.

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

The cost-effectiveness calculations are based on a number of assumptions that include projections of survival in models and interpretation of Quality of Life Data that may be flawed. These form the basis of the summary of recommendations which need further consideration.

1. Section 3.9 Modelling of OS

Much weight was placed on modelling of OS data, taking various assumptions into account. Whatever modelling is used, the trial results show a statistically significant improvement in OS. This means that despite progression and subsequent treatment, patients on mirvetuximab live longer than those treated with conventional chemotherapy. Taking trial data into account, the outcome of patients who were alive at 15 months showed that at 30 months 40% of this group were still alive (O'Malley et al ASCO 2024). Thus, there is a group of longer-term survivors in patients treated with mirvetuximab. It is difficult to predict how many would be alive at 45 or 60 months as there are no data. However, this pattern of prolonged survival in the PROC population is not seen in patients treated with conventional chemotherapy, for whom there is virtually no treatment option beyond the weekly paclitaxel or PLD- the two available NHS approved treatments. These outcome data are further supported by the recently presented PFS2 data (Moore et al ESMO 2025) showing that the HR for PFS2 was 0.59 (95% CI 0.48-0.73) (it was 0.63 (95% CI 0.51-0.79) in the PFS analysis). About 2/3 of patients in both arms received subsequent chemotherapy after progression. As stated above, it would be unusual for the population in England and Wales to receive further standard chemotherapy after progression, so the sustained benefit in PFS2 in the MIRASOL trial would probably be even greater in a UK population treated with mirvetuximab. It should be noted that in England, some patients would access standard of care drugs after failing mirvetuximab.

2. Heath State Utilities section 3.10

There was discussion about which health state utility model to use, and considerable weight was placed on EQ-5D. Putting aside the discussions on which health-utility scale to use, from a clinical perspective, the interpretation of HRQoL data is fraught with difficulties. The key areas of concern are:

a. HRQoL measurements stop soon after progression. This is the time when Quality of life deteriorates rapidly as disease-related symptoms dominate. In England there would be no further chemotherapy option. So, whilst patients remain on Mirvetuximab with a reasonable EQ-5D score, the progressing control arm patients with tumour-related symptoms no longer have QoL measurements captured.

b. The EQ-5D measurements do not adequately take account of the higher tumour response rate seen with mirvetuximab which leads to an early improvement in disease-related symptoms. The ORR was 42% in patients on Mirvetuximab compared with 16% in control patients.

The statement on page 14 : 'It thought that the size of the difference was unlikely to be plausible because people would be expected to have similar subsequent treatments after progression in both arms' is not correct, as stated above, patients on the control arm in England would not receive similar subsequent treatment compared to the mirvetuximab arm.

The third recommendation bullet point relates to age. In the discussion meeting and in the draft summary there is acknowledgement of the uncertainty of the age of the population of patients being treated in England. The recent NOCA data of age of diagnosis are more accurate than a registry cohort taken between 2016-2017. Whatever the age of treatment, it will be greater than in a clinical trial. Clinical trial ages for all oncology trials are invariably younger than in general clinical practice. Thus, is it difficult to justify an age difference as bullet point three for a failure to recommend mirvetuximab (page 4 report).

Clinical Effectiveness with different platinum-free intervals.

Subgroup analysis 3.8 (pg 10)

'It concluded that mirvetuximab may be more clinically effective in people with a primary platinum-free interval of more than 6 months'.

This statement is a cause for concern. There is a danger of over-interpretation of subgroup analysis data. As discussed in the draft document there was an inconsistency between PFS and OS results in the those with primary and secondary platinum-resistance, so it is difficult to draw the conclusion above. There are individual examples (personally shared with me) of people with a primary PFI or less than 6 months who have benefited from mirvetuximab

Are the recommendations sound and a suitable basis for guidance to the NHS?

The recommendation in 3.22 is perverse. The draft guidance acknowledges the PFS and OS benefit, and also that mirvetuximab may improve quality of

life. These are all the characteristics needed for a new treatment of patients at the late phase of disease. There is an opportunity to introduce a drug with acceptable toxicity that leads to a high tumour response rate and improvement of the key outcome parameters required in a clinical trial (PFS and OS).
Furthermore, the use of precision-guided medicine means that only a proportion of people with high folate alpha receptor expression will be eligible for benefit.
Yet despite these statements in 3.22, the committee concluded: 'But, when considering the condition's severity, and its effect on quality and length of life, the most likely cost-effectiveness estimates are above the range that NICE considers an acceptable use of NHS resources'.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

No

Name	[redacted]
Comments on the DG:	

Given the overall survival data observed in MIRASOL I would estimate a 10 year survival rate of 5-10% with mirvetuximab

3.10 - This section of the consultation does not seem to reflect the high burden of cancer related symptoms that patients with platinum-resistant ovarian cancer experience including recurrent ascites and bowel obstruction which often require inpatient admission to hospital. The increased response rates observed with mirvetuximab compared to traditional chemotherapy as well as the shorter time to response would mitigate some of these cancer related symptoms

It should be noted that ocular toxcities are observed in approximately 50% of patients treated with mirvetuximab. It follows, that for approximately half of patients treated with mirvetuximab will require as baseline ophthalmology assessment, which can indeed be performed by an optometrist. These patients, who do not experience oculat toxicities, will not require ongoing ophthalmology assessment

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

Patients with platinum resistant ovarian cancer have a very poor prognosis, standard chemotherapy in this setting has shrinkage (response) rates of 10-20% depending on the prior treatment lines. The response rates (43%) seen with Mirvetuximab have definite clinical benefit in this population of patients with often a high burden of symptoms requiring intensive management in both the in and outpatient setting.

This is the first antibody drug conjugate to show a benefit in this difficult cohort who have limited active treatment options.
The MIRASOL trial is the first study to show an overall survival benefit in this group with platinum resistant disease.
As such this is an important therapeutic advance for this patient group and there is strong clinical support across the UK for access to mirvetuximab for those patients with FR high (>75%) expression.
Selection is feasible in the UK as it involves immuno-histochemistry only.

Age: The average age of participants in the Mirvetuximab Mirasol trial - median age was 64 years (range 32–88) in the mirvetuximab soravtansine (MIRV) arm and 62 years (range 29–87) in the chemotherapy arm, as reported in the intention-to-treat population.
For the subgroup of patients aged 65 and older, the median age was 71 years in the MIRV arm and 70 years in the chemotherapy arm. These data are consistent with the UK population and also reflect a population typical of platinum-resistant ovarian cancer trials, with a substantial proportion of older adults.

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

Longer term survival beyond 5 years is very difficult to predict and fraught with error, there may be a small percentage who have long durations of response on mirvetuximab and then on subsequent therapies and although unexpected, it is likely to be somewhere in the region of 0-3%, particularly with the increasing access to clinical trials in the subsequent settings.

QoL – Health State Utilities: section 3.10 pg 13
There was an improved quality of life seen with mirvetuximab compared with chemotherapy likely related to the response rates.
Although the overall magnitude of benefit did not reach statistical significance the improvements seen in response rate and QOL are an important clinical advance for this group of patients who have a high rate of health care utilisation including inpatient stays.

Are the recommendations sound and a suitable basis for guidance to the NHS?

In my opinion, mirvetuximab offers an important, biomarker based treatment option for patients with limited effective standard treatment options and would support a further review by the committee regarding the approval of this agent.

It is the first trial in the platinum resistant setting to demonstrate improved survival in a group who have a poor prognosis overall. The ability to limit this treatment to the relatively small proportion of patients who are likely to benefit (by alpha folate receptor testing) is a significant advantage.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

No

Name	[redacted]
Comments on the DG:	

The overall survival for a patient with platinum resistant ovarian cancer is <12 months. I fail to see the relevance of lengthily discussion about the statistical models used to calculate 5 and 10 year survival in this context.

Any patient who is alive at 10 years with platinum resistant ovarian cancer, would have cancer biology so different from the vast population that they should be excluded from survival analysis as an outlier.

3.10 - This phrase, and the paragraph associated with it, are the most important thing in this section.

The statistical analysis that makes up the rest of this section is very challenging to follow and obscures that patients, in their own words, feel that their quality of life is better with mirvetuximab versus chemotherapy.

When we think about treatment we weight up the risks/benefits with patients. For chemotherapy, you have the side effects of treatment without the benefit of overall survival. With mirvetuximab, the survival benefit can make patients more accepting of toxicities. In addition, if your survival is limited, coming to a hospital appointment once every 3 weeks means that patients can spend their time living their lives as opposed to weekly paclitaxel, where patients are coming to the hospital for hours at time, once a week for 3 weeks out of every 4.

These factors (time away from hospital and survival benefit) are very important for patients when weighing up treatment choices/toxicities and I think the document fails to capture that.

I would argue that there is equality issues with this decision.
This drug is already FDA/EMA approved meaning that patients outside of the UK have access to this drug. Future clinical trials looking at platinum resistant ovarian cancer will likely mandate prior mirvetuximab treatment for

FRa positive patients and patients can be excluded from future clinical trials (draw comparisons with bevacizumab where this currently happens). Patients with private insurance and/or the financial means to pay for this privately will have access to it. Therefore there will be a socio-economic divide in treatment between those that are able to get access and those that are not - extending beyond the standard of care setting and in the experimental/clinical trial setting.

Name	[redacted]

Comments on the DG:

Has all of the relevant evidence been taken into account?

Yes appropriate trials considered

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

Have commented on clinical effectiveness as below - feel the gamma distribution is not best fit.

Are the recommendations sound and a suitable basis for guidance to the NHS?

The consultation itself commented that these patients have a critical unmet need and haven't really commented that in real world experience the number of patients able to access drug will be small as only approx. third of patients meet the criteria for folate receptor alpha expression so this is not an all-comers drug.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

Age has been taken into account but is being used as a discriminatory factor. however there was a younger age in the trial which would not be real world experience as patients need strict criteria to enter trials and often are younger than target population leading to selection bias

Agree NOCA data highlights average age of diagnosis as 66 years in England and Wales. Unsure why this meant that average age for starting maintenance PARP inhibitors was 69 as first treatment pathway with surgery and chemotherapy is usually 9-10 months so would have expected PARP inhibitors to be started closer to 67 than 69. patients in clinical trials are often younger than average population which reflects the bias of those who want to participate in trials and meet inclusion criteria

Rosella trial - recent trial with nab-paclitaxel in platinum resistant ovarian cancer 60% patients had received previous PARP inhibitors. In Keynote B96 presented in abstract at ESMO, Berlin 2025 35% had previous PARP inhibitor so not sure comment regarding that MIRASOL was associated with lower rate of PARPi than in clinical practice is appropriate with range in other trials in this setting

Evidence more about patients progressing on PARP inhibitors rather than after (exploratory analysis from PAOLA-1 trial) - agree with clinical experts

strong evidence base that the longer the platinum free interval the higher the response rate to SACT at all stages in ovarian cancer treatment - therefore a longer platinum free interval would be expected to be associated with a better response to any treatment and if PFI was less than 6 months would expect a worse response so not discriminatory

Understand concern of censoring but doubling of patients alive at 3 years on Mirvetuximab compared to chemotherapy which lends significance to plausibility of longer term survival data and the challenges of modelling in this scenario. Based on data seen so far the gamma distribution seems a very low fit for the 5 year survival.

Alternative data sources for chemo OS extrapolations: These patients are a poor prognostic group and difficult to predict outcome to new treatment options of ADC.
ROSELLA trial in PROC overall survival in Nab-paclitaxel arm was 11.5 months.
In B96 (abstract ESMO) control arm of weekly paclitaxel +/- Bevacizumab (CPS >1) was 14 months.

The company also noted that mirvetuximab was associated with a statistically significant improvement in time to second disease progression compared with pooled chemotherapy (HR 0.59, 95% CI 0.48 to 0.73). - This is an important indicator as previously noted if longer treatment free interval - increased response rate to subsequent treatment. cannot assume all patients will be able to receive later lines of therapy due to patient attrition which has always meant challenging to predict sequencing. Lower RR and shorter TTST likely to decrease chances of receiving any subsequent treatment. EAG commented both groups would receive further treatment but this can't be presumed.

Agree for anaemia but often not able to manage neutropoenia if associated with infection as day case.

Agree for anaemia but often not able to manage neutropoenia if associated with infection as day case. It can be managed as day case for patients who have easy transport and live close to hospital but less likely for those who live a distance from hospital. The MASCC Risk Index is an internationally validated scoring system that identifies these low risk patients that can potentially be treated as an outpatient with early antibiotics but advised IP

stay if scored as high risk (age over 60 is included in assessment which covers majority patient age range it this consultation)

Agree with clinical experts on these comments over EAG

Don't agree with EAG as this group of patients at high risk of complications e.g. bowel obstruction and very different to patients in first recurrence. Our local practice is 3-4 weekly on treatment

This is the first new drug in PROC which is classed as the most severe stage of ovarian cancer. Introduction discusses inequality of treatment (Bevacizumab is available in this setting in Scotland with significant improved RR and PFS) and with no new drugs in PROC for years in England and Wales this is a critical unmet need for these patients

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

Yes with regard to mirvetuximab however there appears to be a lack of appreciation of the unmet need in this group of patients with often very symptomatic advanced disease without likelihood of meaningful benefit from standard of care and the associated burden ie the control arms considered here

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

It is important not to to underestimate the the significance of benefit both in terms of response rate (patients often symptomatic with ascites, pleural effusions and serosal bowel involvement) and quality of life. There is little to offer therapy wise in this group. A targeted line of effective therapy is hugely important for our patient group.
Quality of Life data are always challenging to interpret and often the necessary tools required fail to detect the meaningful improvements experienced by patients and seen by oncologists.
There is an overall survival benefit with mirvetuximab which is acknowledged in the draft guidance but there is little comment on treatment after progression and PFS2. It is always difficult to estimate the long-term outcome, but the shape of the curve suggests that at least some patients may live longer and the trial may overestimate the overall survival of the general population receiving standard of care chemotherapy.

Are the recommendations sound and a suitable basis for guidance to the NHS?

This is the first clinically beneficial "precision-medicine" therapy in this setting of unmet need with a clearly defined subgroup defined by a validated biomarker. If we are unable to access this therapy for our patient group, not

only will we fall further behind with outcomes compared with other countries but also find it increasingly difficult to contribute to clinical trials as our standard of care falls short again, rendering our patients ineligible.
I believe this warrants further review

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

The statements regarding the slightly lower age of patients in the trial are of concern and I would agree with the clinical expert opinion that age of diagnosis is not likely to affect outcomes in ovarian cancer and that most clinical trials recruit younger people than in real world populations but none that I can see otherwise

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

Whilst the committee as examined the data from the Mirasol trial, the context of Platinum resistant ovarian cancer (PROC)needs to be further described in order to appreciate the benefit this therapy brings.
PROC represents a population with profound unmet need. Prognosis is poor, treatment options are limited, and existing chemotherapies offer modest efficacy with significant toxicity. Many patients I see have already experienced neuropathy, fatigue, alopecia, and myelosuppression, which directly affect quality of life and willingness to continue treatment.
The appraisal does not sufficiently weight the severity of disease, the lack of effective alternatives, or the importance of therapies that offer meaningful benefit with improved tolerability in later lines of treatment.
This is the first trial to demonstrate a significant increase in OS in addition to PFS. Furthermore, it is a biomaker directed therapy restricting treatment to those most likely to benefit and limiting cost (financial, time and toxicity) to those that unlikely to.
The improvement in overall response rate should not be underestimated. 42% with mirv vs 16% with chemo. these patients often have a large volume of disease and are highly symptomatic . A near tripling of response rate means more patients will experience a reduction in their disease related symptoms therefore improving the QoL.
The appraisal places disproportionate emphasis on uncertainty in overall survival estimates, despite the recognised challenges of demonstrating mature OS data in this indication due to subsequent therapies,and small patient populations. Progression-free survival (PFS), objective response rate (ORR), and duration of response are clinically meaningful endpoints in PROC and are highly relevant to patients.
Mirvetuximab has demonstrated:

• Clinically meaningful improvements in PFS compared with standard chemotherapy
• Improved overall response rates (46% versus 16%), which results in meaningful improvements in patients symptoms
• Durable responses in a setting where responses to chemotherapy are typically short-lived
Discounting these benefits risks undervaluing a therapy that offers real-world clinical improvement

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

No. While the summaries accurately describe the limitations of the evidence, they place disproportionate weight on uncertainty in overall survival and do not adequately reflect clinically meaningful benefits such as progression-free survival, response rate, and duration of response, which are highly relevant in platinum-resistant ovarian cancer.
Long-term survival and cost effectiveness (Section 3.9, page 12): Long-term survival beyond five years is inherently difficult to predict in this population. However, it is plausible that a small proportion of patients treated with mirvetuximab experience prolonged responses and derive further benefit from subsequent therapies.
While such outcomes are uncommon, they are not unexpected and are likely to occur in a small minority of patients, estimated at approximately 0–3%, particularly given increasing access to novel therapies within clinical trials ain later lines of therapy.

The interpretation also underestimates the value of biomarker selection in an FRα-high population, which reflects current best practice and should be considered a strength of the evidence. In addition, the cost-effectiveness conclusions rely on conservative modelling assumptions that may not reflect real-world clinical practice and are highly influential on the ICER.
Overall, the summaries are overly cautious and do not fully account for disease severity, unmet need, and quality-of-life benefits, and therefore do not represent a balanced interpretation of the evidence.
Quality of Life
Compared with conventional chemotherapy, mirvetuximab demonstrates a differentiated safety profile, with reduced rates of severe systemic toxicities such as neutropenia, alopecia, and neuropathy. Neuropathy can be very disabling for patients and result in impaired function and reduced QoL.
Whilst there is a higher rate of ocular adverse events, generally my experience to date (within clinical trials and compassionate access scheme) is that these are very manageable with appropriate prophylaxis and reversible with mitigation strategies.
The appraisal does not adequately reflect how improved tolerability translates into better quality of life, treatment persistence, and patient preference—factors of particular importance in a palliative setting.

Are the recommendations sound and a suitable basis for guidance to the NHS?

I believe that the committee should reconsider their decision. Mirvetuximab offers a biomaker directed therapy in a patient group with no good treatment options and poor prognosis. My experience to date is that this is a well tolerated treatment with a preferable toxicity profile.

Name	[redacted]

Comments on the DG:

Has all of the relevant evidence been taken into account?

Yes

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

No. We believe this drug represents a more effective option for patients as demonstrated by improved response rates and overall survival reducing the likelihood of them developing distressing and difficult disease related symptoms that take up significant NHS resource and inpatient bed time e.g ascites drainage / bowel obstruction management. Given the incremental benefit this survival benefit offers we do not believe the committee has adequately considered the survival at 5 years in the Mirvetuximab group.

Are the recommendations sound and a suitable basis for guidance to the NHS?

No. This group of patients represent a group with a significant unmet need in terms of treatment options with no novel therapies for 20 years in this setting. This new novel mechanism of action and low toxicity profile agent that despite being used in a heavily pre-treated population has shown an overall survival advantage would allow patients to live more fulfilled better quality lives than with chemotherapy.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

No

We are commenting as a group of medical and clinical oncologists working at one of the UK largest trusts and gynaecological cancer centres. We believe that Mirvetuximab meets a significant unmet need in a population of patients that currently have very limited treatment options. Patients with platinum resistant disease suffer a multitude of unpleasant disease-related symptoms. Mirvetuximab offers a clinically meaningful improved response

rate, meaning that the chance of patients progressing to develop complications from their disease is less likely than with standard of care options. Complications such as bowel obstruction / recurrent ascites are extremely distressing for patients, impact their quality of life enormously as well as take large amounts of NHS resource to manage.
Mirvetuximab represents a well tolerated drug with a better side effect profile than standard of care chemotherapy enabling patients to enjoy a better quality of life for longer. In clinical practice the ocular toxicity has not been onerous to manage with some patients requiring no ophthalmology input after baseline assessments at all and others infrequent rapid assessment only.
Given the novel mechanism of action and additive incremental survival benefit using Mirvetuximab we would support the comments made by the clinical experts.

Name	[redacted]
Comments on the DG:	

I do not agree with this decision and believe Mirvetuximab should be NICE approved and available for patients within the UK.

The severity of platinum resistant ovary cancer is determined by the lack of meaningful treatment options for these women.

This is a cancer of unmet need; especially as the vast majority of women with a diagnosis of ovary cancer will eventually become platinum resistant over the course of their life time with this illness.

Through the MIRASOL trial, we have had individuals respond and have clinically meaningful QoL in keeping with the overall data.

The response rates are high, meaning patients symptoms will improve to allow them to maintain a good QoL with less burden and resources on the NHS for palliatively managing their symptoms.

There is also PFS2 benefit after treatment, again allowing for less clinical intervention / costs post treatment.

The NICE guidance has not factored in the savings on NHS resources / clinical time gained by meaningful clinical responses / QoL / Progression Free Survival 2 (PFS2) post treatment in this group of cancer patients with current unmet clinical need.

I believe it is vital I am able to offer this treatment on the NHS to my patients.

Name	[redacted]
Comments on the DG:	

Has all of the relevant evidence been taken into account?

Clinically patients with platinum resistant ovarian cancer have a very poor prognosis, standard chemotherapy in this setting has shrinkage (response) rates of 10-20% depending on the prior treatment lines. Mirvetuximab offers an active (response rates of 43%), precision approach to treatment based on the presence of folate receptor (FR) high ovarian cancer. Response rate is an important consideration as this has a direct positive impact on managing and offsetting disease symptoms such as bowel obstruction (again reducing inpatient treatment).

This is the first precision medicine trial to show a benefit in this difficult cohort who have limited active treatment options.
The MIRASOL trial met its key PFS and Overall survival end points and is the first study to show an overall survival benefit in this group with platinum resistant disease.
As such this is an important therapeutic advance for this patient group and there is strong clinical support across the UK for access to mirvetuximab for those patients with FR high (>75%) expression.
This agents use is restricted to this cohort as a previous study did not demonstrate benefit in an allcomer group of patients.
Selection is feasible as it involves immuno-histochemistry only.
As patients receive mirvetuximab on the MIRASOL study they subsequently have access to standard platinum resistant chemo options such as weekly taxol and perhaps other trial strategies. The number of phase 1 options is increasing and so a 10% survival at 5 years could now be feasible with the additional option of mirvetuximab.
Age: The average age of participants in the Mirvetuximab Mirasol trial - median age was 64 years (range 32–88) in the mirvetuximab soravtansine (MIRV) arm and 62 years (range 29–87) in the chemotherapy arm, as reported in the intention-to-treat population.
For the subgroup of patients aged 65 and older, the median age was 71 years in the MIRV arm and 70 years in the chemotherapy arm. These data are consistent with the UK population and also reflect a population typical of platinum-resistant ovarian cancer trials, with a substantial proportion of older adults.

Are the summaries of clinical and cost effectiveness reasonable interpretations of the evidence?

Long Term survival – Cost Effectiveness: Section 3.9 pg 12: longer term survival beyond 5 years is very difficult to predict- there may be a small percentage who have long durations of response on mirvetuximab and then on subsequent therapies and although unexpected, it is likely to be somewhere in the region of 0-3%, particularly with the increasing access to clinical trials in the subsequent settings.
QoL – Health State Utilities: section 3.10 pg 13
the quality of life of patients on mirvetuximab was improved compared to chemotherapy, and this is likely to be due to the improved response rates

and durations of response with this agent - this is generally a group of patients with significant symptoms due to a heavy disease burden and who are at risk of repeated admission for symptom control. Although the overall magnitude of benefit did not reach statistical significance the improvements seen in response rate and QOL are an important clinical advance for this group of patients

Are the recommendations sound and a suitable basis for guidance to the NHS?

I believe that mirvetuximab offers an important, biomarker based treatment option for patients with limited effective standard treatment options and would support a further review by the committee regarding the approval of this agent.

It is the first trial in the platinum resistant setting to demonstrate improvements in survival in a group who have a poor prognosis overall and further more it has clearly defined a subgroup who derive the greatest benefit and this is also an important consideration as we have a way to select the patients who are most likely to benefit and spare others from treatment.

Are there any aspects of the recommendations that need particular consideration to ensure we avoid unlawful discrimination against any group of people on the grounds of race, gender, disability, religion or belief, sexual orientation, age, gender reassignment, pregnancy and maternity?

No

Name	[redacted]
Comments on the DG:	

3.5 Our UK site recruited the highest number of patients to MIRASOL and in my view, The MIRASOL population is representative and applicable to UK clinical practice.

3.9 I agree with the clinical experts that it is plausible to have a 10% survival rate in the mirvetuximab arm at 5 years. For standard of care chemotherapy, anecdotally my sense is survival at 5 years is less than 5%-0-2%.
At 10 years, the survival rate with standard of care chemotherapy is anecdotally 0%. With mirvetuximab, I expect this to be higher than standard of care chemotherapy 2-5%

I very much hope NICE reconsiders the decision. I have seen first hand, as an investigator recruiting and managing patients in the MIRASOL trial, how Mirvetuximab has had a positive impact on the lives of patients with

platinum-resistant ovarian cancer interms of survival, quality of life and reduced toxicities compared to current standard of care chemotherapy.

3.5 Our UK site recruited the highest number of patients to MIRASOL and in my view, The MIRASOL population is representative and applicable to UK clinical practice.

agree with the clinical experts that it is plausible to have a 10% survival rate in the mirvetuximab arm at 5 years. For standard of care chemotherapy, anecdotally my sense is survival at 5 years is less than 5%- 0-2%.
At 10 years, the survival rate with standard of care chemotherapy is anecdotally 0%. With mirvetuximab, I expect this to be higher than standard of care chemotherapy 2-5%

NDRS-NICE partnership report

Background

This report was produced in partnership by the National Disease and Registration Service (NDRS) and National Institute for Health and Care Excellence (NICE). NDRS and NICE have established a partnership focused on routinely collected data to support NICE decision making on the appraisals of cancer treatments. The partnership uses NDRS datasets, including the information submitted by trusts to the Systemic Anti-Cancer Therapy (SACT) dataset,[1] to provide an understanding of current practice.

To determine a severity modifier, NICE considers factors such as the age, gender, and overall survival of the patient cohort affected by the disease. Additionally, knowing the time-on-treatment for each therapy is useful, as it validates assumptions made in technology appraisal evaluations about the duration of treatment use.

This partnership is focused on producing demographic and survival information using NDRS data, alongside supplementary information tailored to each technology appraisal. These may include, for example, the time patients spend on particular treatments, genetic data where this is available, or other information on real-world care pathways. Interpretation of the data is not included in this report, it is the information as provided to the NICE technology appraisal committees. Detail on how NICE health technology appraisals use this data can be found in the NICE health technology evaluations manual,[2] with specific information relating to the survival analysis modelling available in Technical Support Document (TSD).[3]

The focus of this report is the indication **ID6442: Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer**

A single cohort was assessed for this indication:

[1] Chloe J. Bright et al., "Data Resource Profile: The Systemic Anti-Cancer Therapy (SACT) dataset," *International Journal of Epidemiology* 49, no. 1 (February 2020): 15–15l, https://dx.doi.org/10.1093/ije/dyz137.

[2] *NICE health technology evaluations: the manual (2025) NICE process and methods PMG36. Last updated 23 October 2025*, n.d., https://www.nice.org.uk/process/pmg36.

[3] Latimer Nicholas, *NICE DSU Technical Support Document 14: Undertaking survival analysis for economic evaluations alongside clinical trials - extrapolation with patient-level data*, 2011, http://www.nicedsu.org.uk/.

- Adults with platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer treated with pegylated liposomal doxorubicin (PLD) or paclitaxel monotherapies (pooled chemotherapy cohort)

Age and overall survival for adults with platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer

Introduction

This report was produced in partnership by the National Disease and Registration Service (NDRS) and National Institute for Health and Care Excellence (NICE). It presents overall survival and age distributions among patients aged 18 or over with platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer treated with pegylated liposomal doxorubicin (PLD) or paclitaxel monotherapies (pooled chemotherapy).

Method

A snapshot of SACT data was taken on 7th December 2025 and made available for analysis on 19th December 2025. SACT data is only considered complete when 90% of trusts have submitted data, which at the time of analysis was 31st March 2025. This date is used as the upper limit when selecting regimens of interest. Patients were traced for their vital status on 5th October 2025, which is the censoring date for the overall survival analysis.

Descriptive statistics of age were computed, along with Kaplan-Meier estimates and parametric fits for overall survival. Patients were censored at the date of the most recent trace (5th October 2025), representing the last date on which vital status was confirmed.

Cohort inclusions / exclusions

Patients were included if they met all of the following:

- Diagnosed between 1st January 2010 and 31st December 2023
- Gender recorded as female
- Country code was England, based on postcode of residence at diagnosis
- Age at diagnosis date was 18 or over
- ICD-10 diagnosis code was one of the following:
  - ‘C56’ - Malignant neoplasm of ovary
  - ‘C570’ - Malignant neoplasm of other and unspecified female genital organs: fallopian tube
  - ‘C481’ - Malignant neoplasm of retroperitoneum and peritoneum: specified parts of peritoneum
  - ‘C482’ - Malignant neoplasm of retroperitoneum and peritoneum: peritoneum, unspecified
- Only one tumour was recorded during the study period
- No registration for another malignant neoplasm within the 36 months preceding diagnosis

- PLD or paclitaxel monotherapy was initiated on or after 27th April 2016 (NICE TA389 publication date). Usage before this point would be through the Cancer Drugs Fund or compassionate use schemes
- PLD or paclitaxel monotherapy was initiated on or before the point at which SACT is considered complete (31st March 2025)
- PLD or paclitaxel monotherapy was not recorded as being administered in an adjuvant/neoadjuvant or curative setting
- Individuals had received treatment with a platinum-based therapy (cisplatin, carboplatin, oxaliplatin) prior to initiating PLD or paclitaxel monotherapy

Note: Folate receptor-α genetic status was not considered due to low data completeness.

Identification of platinum resistant cases

PLD and paclitaxel monotherapies are recommended as treatments for individuals with platinum-resistant disease, defined as disease progression occurring within 6 months of the last platinum-based chemotherapy regimen. Platinum-resistance may arise following 1st line platinum-based therapy or after subsequent lines of treatment. As PLD or paclitaxel monotherapy is recommended only for platinum-resistant disease, initiation of either monotherapy was used as a proxy indicator for platinum-resistance.

Owing to variation in SACT recording practices and the structure of SACT tables, it can be challenging to algorithmically distinguish PLD and paclitaxel monotherapies from other lines of therapy, where these agents are given in combination with a platinum-based therapy (e.g. paclitaxel plus carboplatin). These combinations may be grouped at the regimen level in SACT or recorded as contemporaneous but separate ('split') regimens.

To reduce misclassification of PLD or paclitaxel monotherapies, we: (i) count only regimens where the NDRS-categorised description ("benchmark group") specifies PLD or paclitaxel alone; (ii) exclude regimens where a platinum-based therapy appears in the drug-level tables for a PLD or paclitaxel monotherapy regimen (iii) exclude regimens where a drug-level record of a platinum-based therapy occurs within ±7 days of the PLD or paclitaxel monotherapy regimen start date. When given in combination PLD or paclitaxel is usually administered on the same day as a platinum agent. This ±7-day window was chosen as a pragmatic buffer to allow for a degree of real-world variation in clinical practice.

Sensitivity analyses

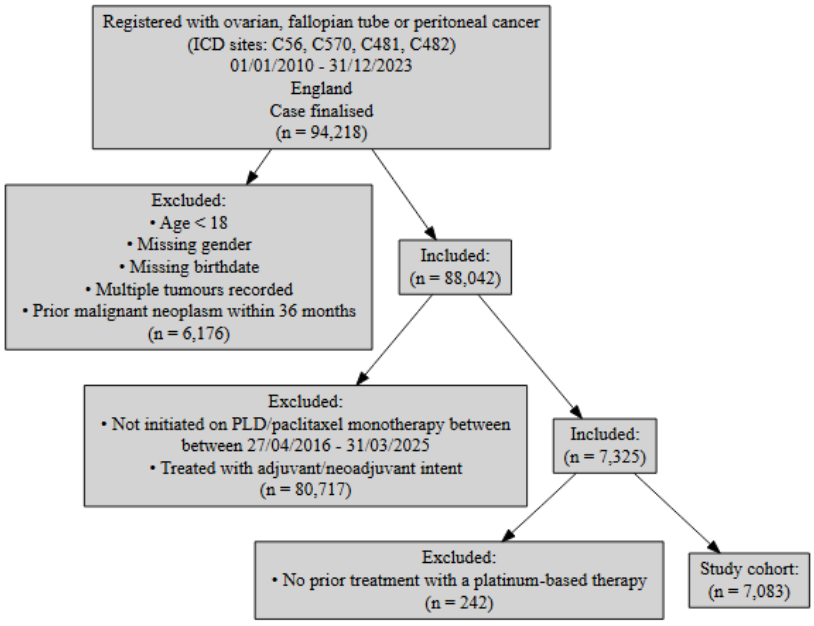
To assess the robustness of the study findings, a series of sensitivity analyses were conducted. These analyses examined the impact of varying the inclusion and exclusion criteria used to define the study population, and how these variations influenced both the size of the study population and the estimated overall survival.

The table below summarises the sensitivity analyses undertaken and their corresponding effects on population size and overall survival estimates.

Assumption	Population	N	Median survival	Restricted mean survival (Whole curve)
-	Base population: OFP diagnosis, any stage at diagnosis, PLD/paclitaxel monotherapy initiated, prior platinum-based therapy	7,083	8.54 months	13.57 months
Morphology	Base population, but only individuals with an epithelial morphology code (stricter population)	7,004	8.51 months	13.54 months
Staging at diagnosis	Base population, but only individuals with stage 3/4 at diagnosis (stricter population)	5,798	8.51 months	13.19 months
Intent of treatment	Base population, but including PLD or paclitaxel regimens given with adjuvant, neoadjuvant or curative intent (relaxed population)	7,331	8.54 months	13.62 months
Prior platinum-based therapy	Base population, but removing need for a prior platinum-based therapy (relaxed population)	7,596	8.61 months	13.82 months

Table 1: Sensitivity analyses

Flow chart



Patient acknowledgement

This work uses data that has been provided by patients and collected by the NHS as part of their care and support. The data is collated, maintained and quality assured by the National Cancer Registration and Analysis Service, which is part of NHS England.

Results

Age at start of treatment

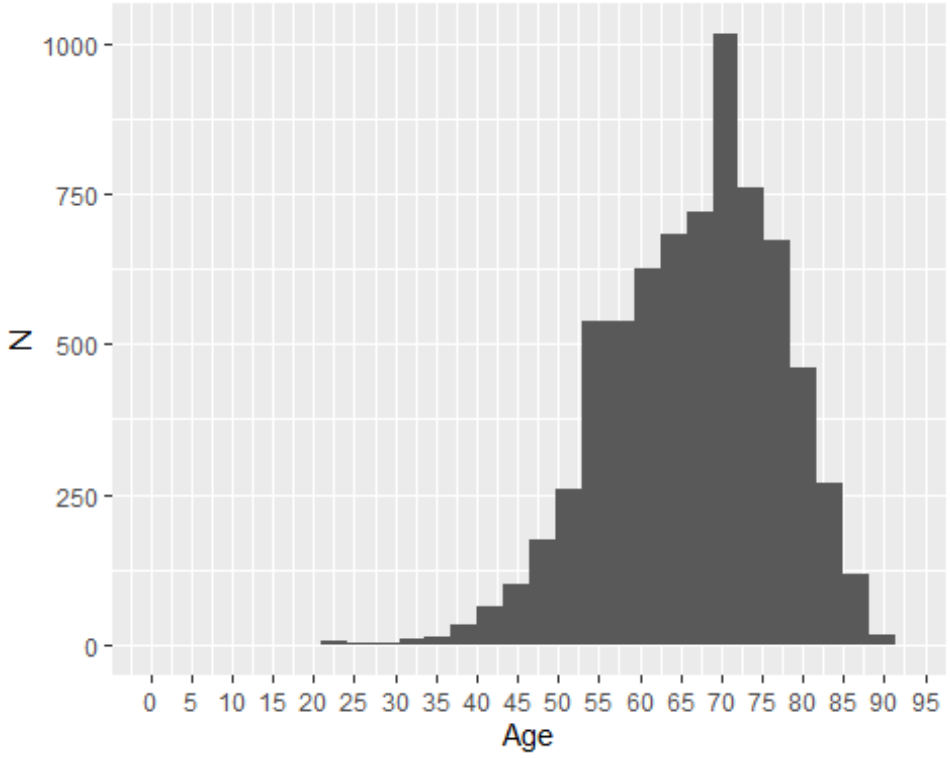
The table below sets out the mean age, standard deviation, median age and interquartile range (IQR) of patients who have received PLD or paclitaxel for platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer. Age is measured at the commencement of the first treatment regimen of PLD or paclitaxel monotherapy.

Characteristic	**N = 7,083**[1]
Age at start of regimen	67, (10) : 68 (60, 75)

[1]Mean, (SD) : Median (Q1, Q3)

Table 2: Mean age, standard deviation, median age and IQR of patients who have received PLD or paclitaxel monotherapy

Figure 1: Age distribution of patients who have received PLD or paclitaxel monotherapy



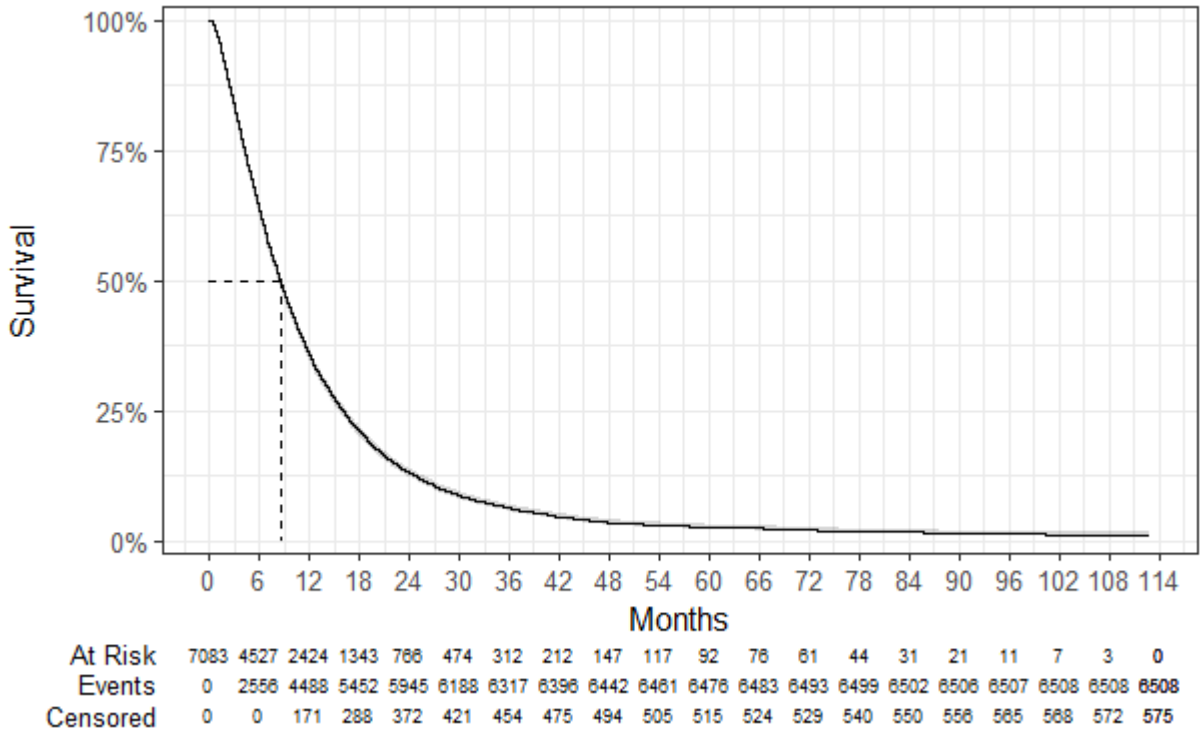
Overall survival

Base K-M plot

The Kaplan-Meier plot below shows survival over time for those receiving a treatment regimen of PLD or paclitaxel monotherapy.

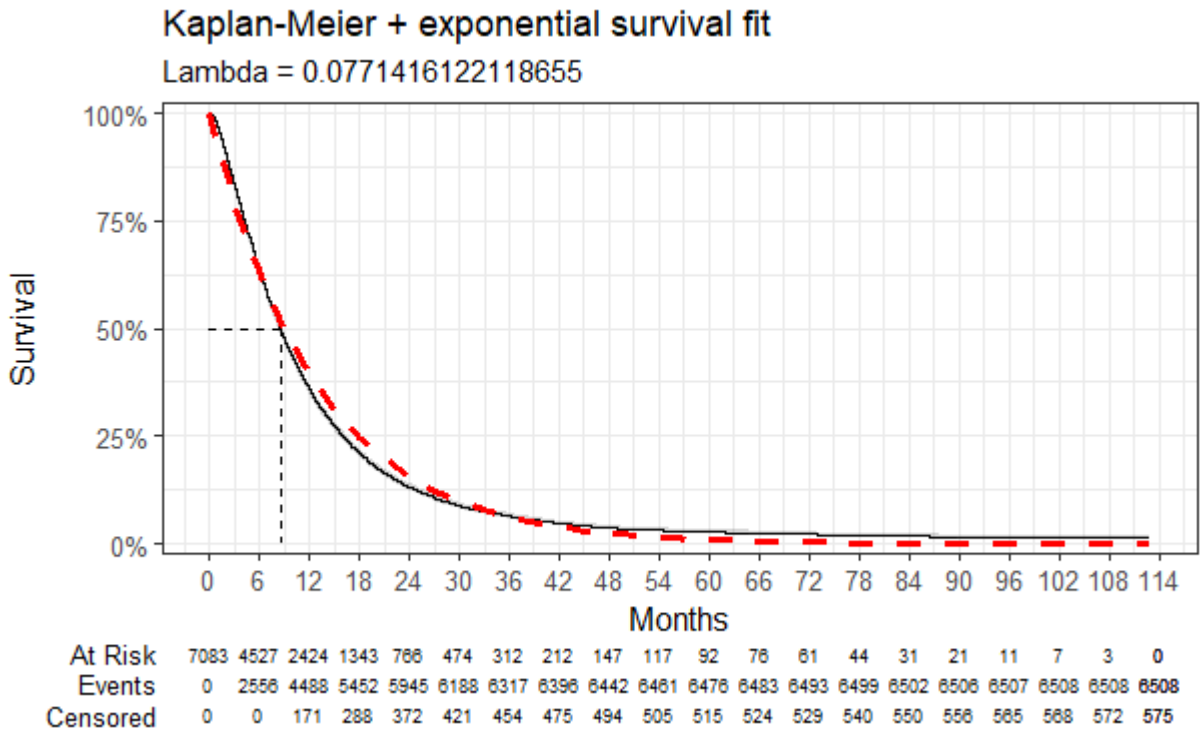
Median survival was 8.54 months. Restricted mean survival (over the whole curve) was 13.57 months. The minimum follow-up time was 0.1 months, median 8.3 months, and maximum follow-up time of 113 months.

Figure 2: Overall survival amongst patients who have received PLD or paclitaxel monotherapy



Exponential

Figure 3: Overall survival against exponential survival function



Parameter	Estimate	Std. Error	z	p-value
(Intercept)	2.562	0.012	206.6912	0

log-likelihood = -23182.2276724422

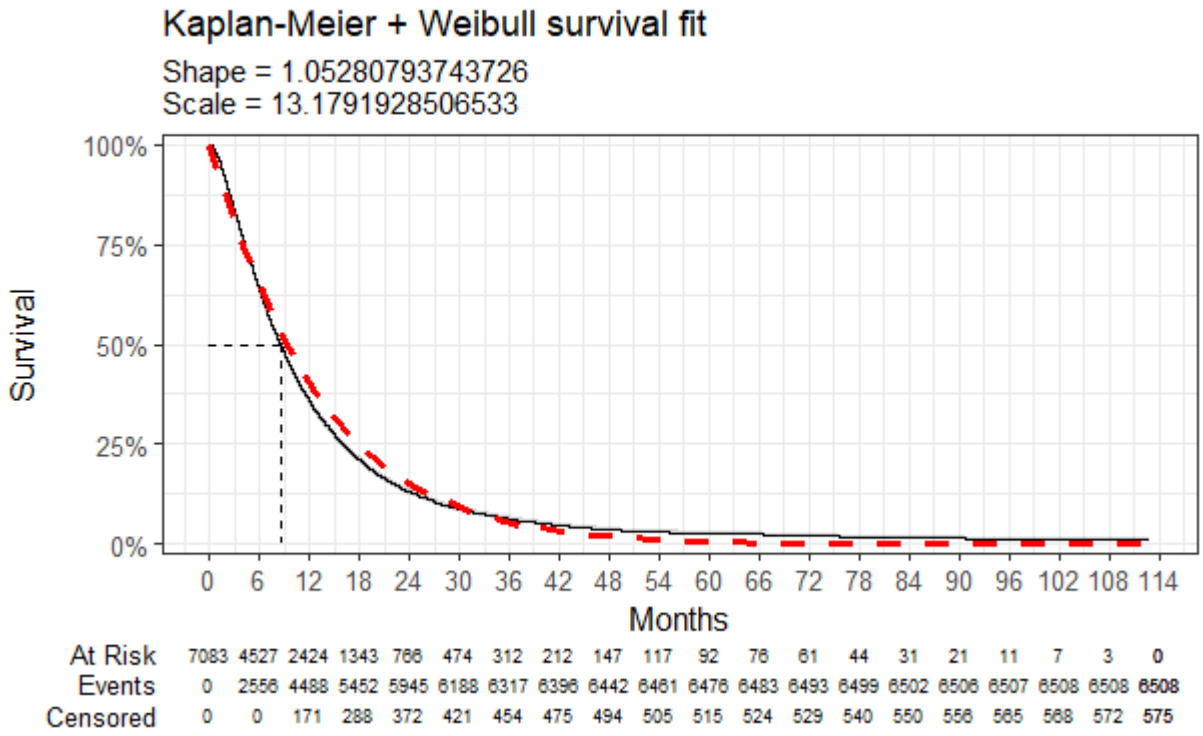
AIC = 46366.4553448843

BIC = 46373.3207977101

Table 3: Survival model fit summary (exponential distribution)

Weibull

Figure 4: Overall survival against Weibull survival function



Parameter	Estimate	Std. Error	z	p-value
(Intercept)	2.579	0.012	211.937022	0.000000e+00
Log(scale)	-0.051	0.009	-5.572525	2.510734e-08

log-likelihood = -23167.1702767167

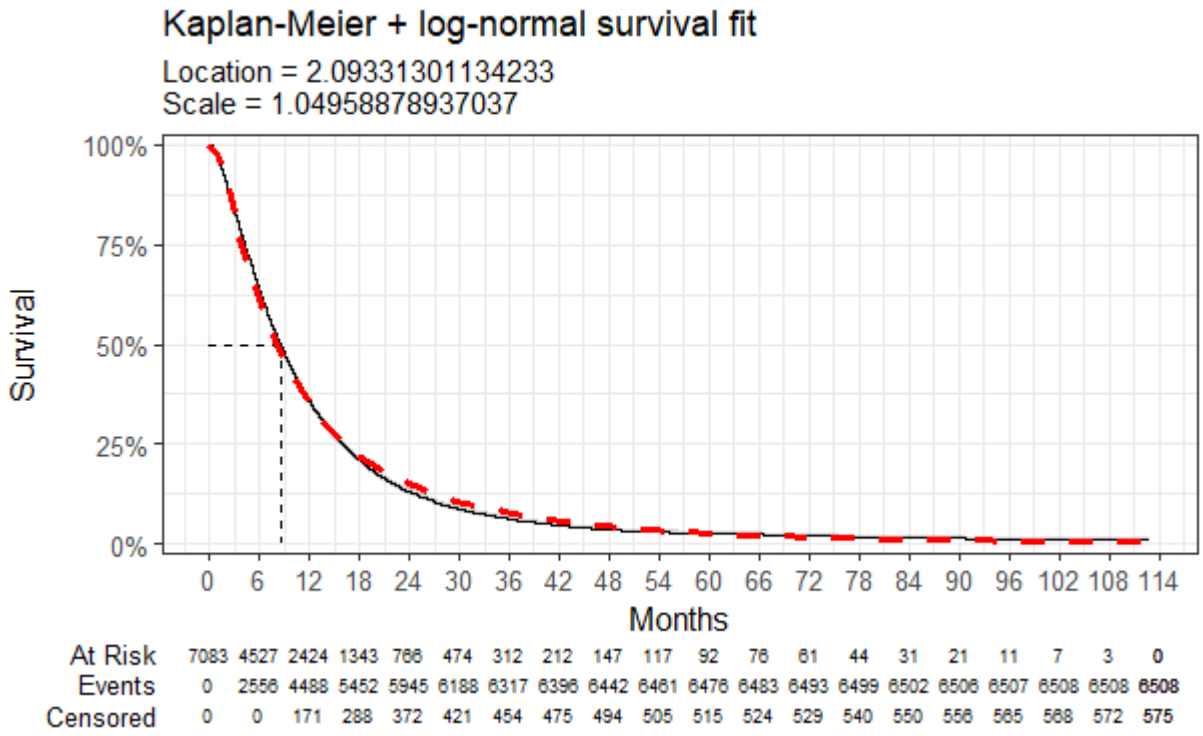
AIC = 46338.3405534333

BIC = 46352.0714590848

Table 4: Survival model fit summary (Weibull distribution)

Log-normal

Figure 5: Overall survival against log-normal survival function



Parameter	Estimate	Std. Error	z	p-value
(Intercept)	2.093	0.013	166.044396	0.00000e+00
Log(scale)	0.048	0.009	5.447309	5.11377e-08

log-likelihood = -22889.3889718521

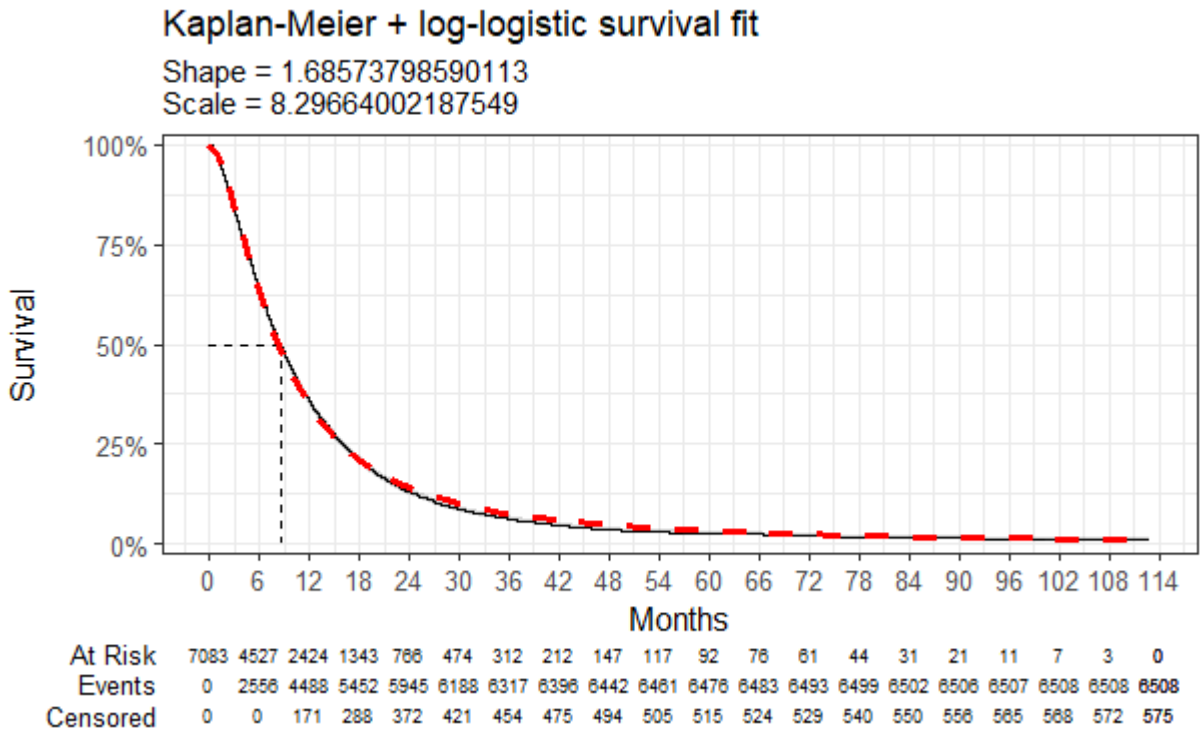
AIC = 45782.7779437041

BIC = 45796.5088493556

Table 5: Survival model fit summary (log-normal distribution)

Log-logistic

Figure 6: Overall survival against log-logistic survival function



Parameter	Estimate	Std. Error	z	p-value
(Intercept)	2.116	0.012	172.29577	0
Log(scale)	-0.522	0.010	-50.60072	0

log-likelihood = -22851.9012999959

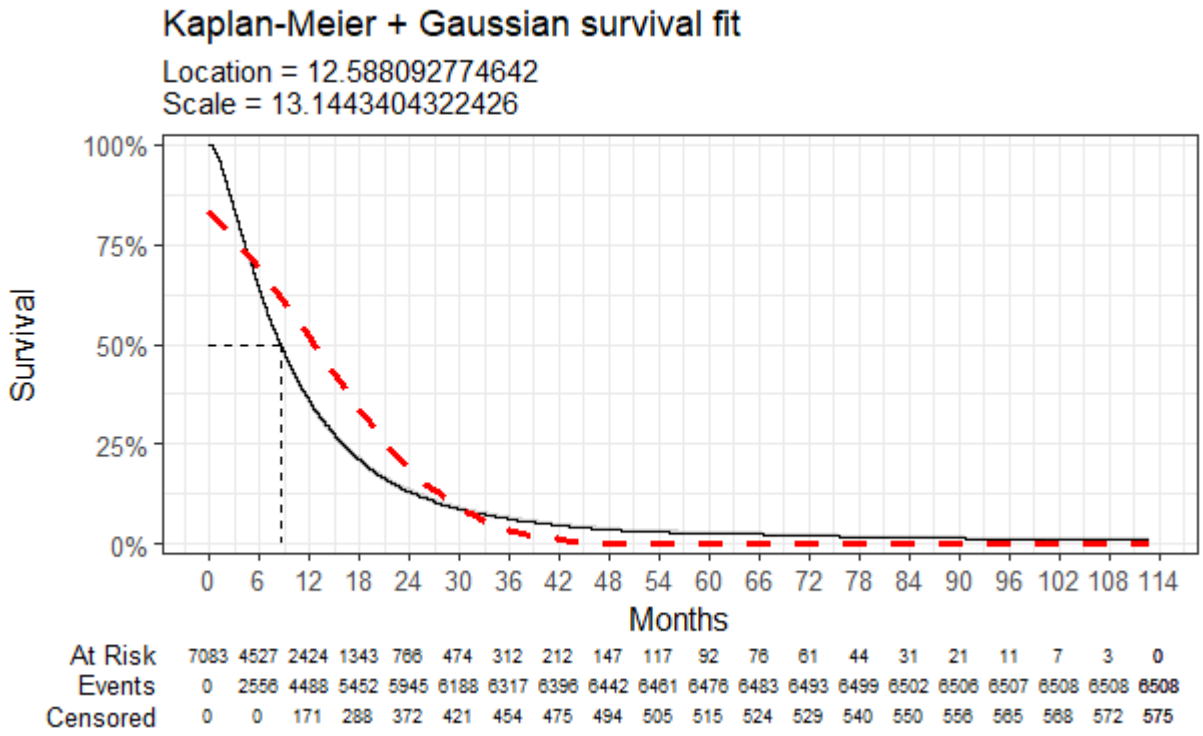
AIC = 45707.8025999917

BIC = 45721.5335056432

Table 6: Survival model fit summary (log-logistic distribution)

Gaussian

Figure 7: Overall survival against Gaussian survival function



Parameter	Estimate	Std. Error	z	p-value
(Intercept)	12.588	0.158	79.63743	0
Log(scale)	2.576	0.009	290.50460	0

log-likelihood = -26584.3127692051

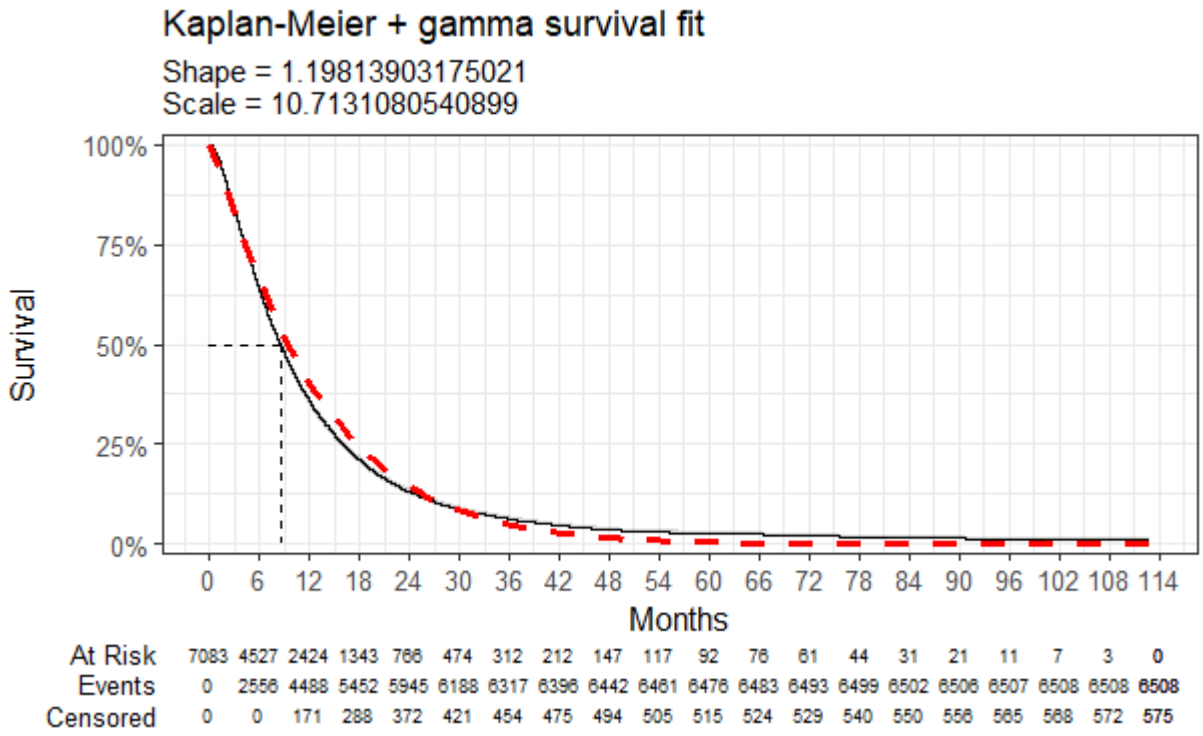
AIC = 53172.6255384101

BIC = 53186.3564440616

Table 7: Survival model fit summary (Gaussian distribution)

Gamma

Figure 8: Overall survival against gamma survival function



Parameter	Estimate	Std. Error	L95.	U95.
shape	1.198	0.019	1.16215526	1.23523697
rate	0.093	0.002	0.08977813	0.09705066

log-likelihood = -23117.8399982382

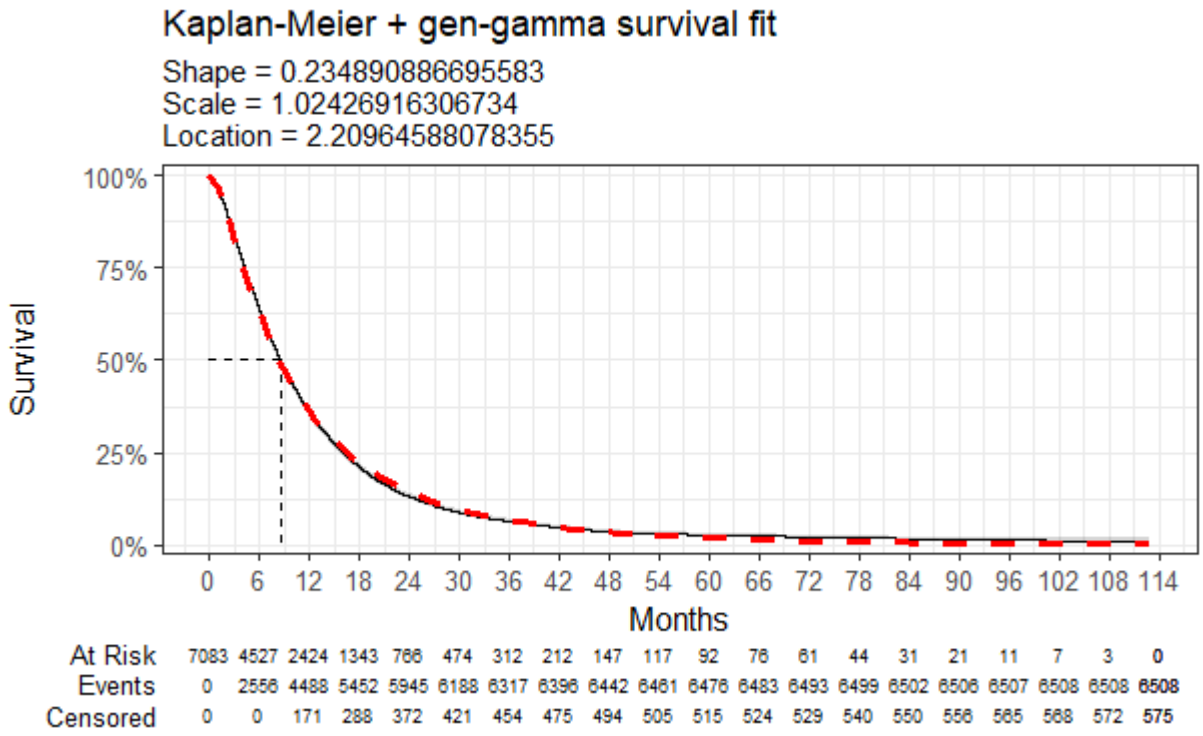
AIC = 46239.6799964763

BIC = 46253.4109021278

Table 8: Survival model fit summary (gamma distribution)

Generalised gamma

Figure 9: Overall survival against generalised gamma survival function



Parameter	Estimate	Std. Error	L95.	U95.
mu	2.210	0.019	2.1718038	2.2474880
sigma	1.024	0.010	1.0053513	1.0435430
Q	0.235	0.030	0.1757688	0.2940129

log-likelihood = -22859.1249162947

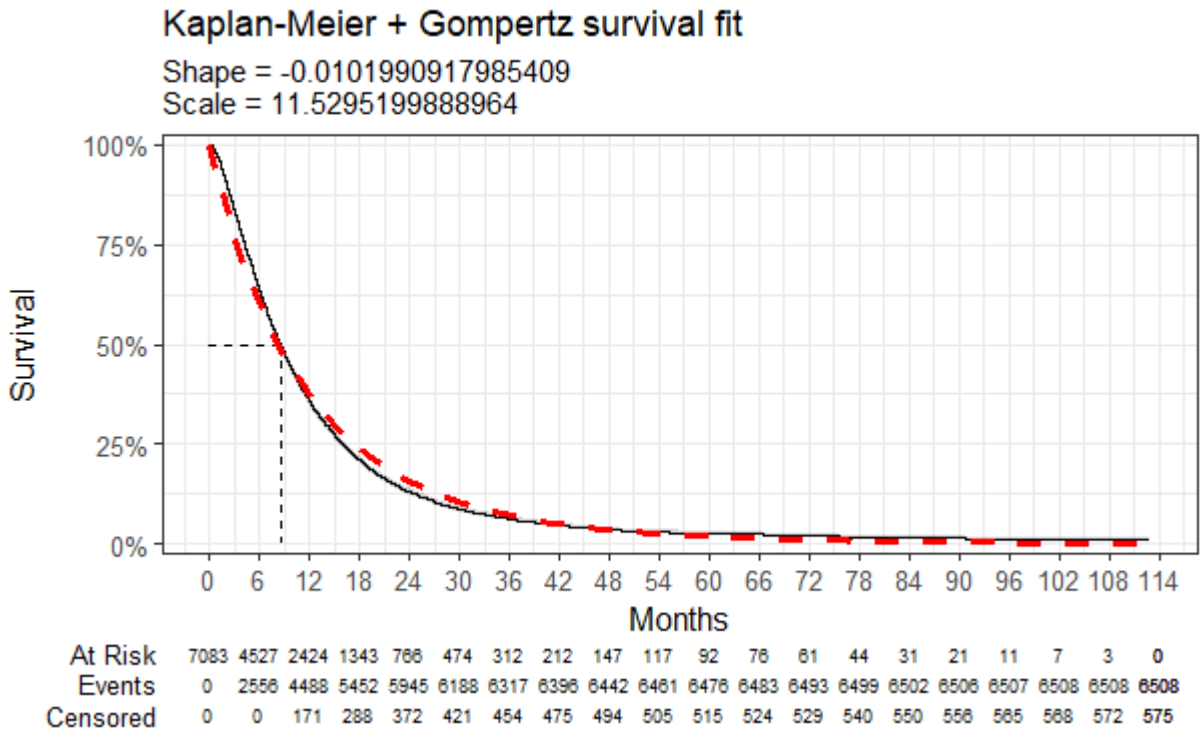
AIC = 45724.2498325894

BIC = 45744.8461910667

Table 9: Survival model fit summary (generalised gamma distribution)

Gompertz

Figure 10: Overall survival against Gompertz survival function



Parameter	Estimate	Std. Error	L95.	U95.
shape	-0.010	0.001	-0.01219336	-0.008204822
rate	0.087	0.001	0.08398053	0.089577495

log-likelihood = -23125.8424105135

AIC = 46255.6848210271

BIC = 46269.4157266786

Table 10: Survival model fit summary (Gompertz distribution)

Single Technology Appraisal

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]

EAG report – factual accuracy check and confidential information check

"Data owners may be asked to check that confidential information is correctly marked in documents created by others in the evaluation before release." (Section 5.4.9, NICE health technology evaluations: the manual).

If you do identify any errors in the marking of confidential information you must inform NICE by **5pm** on **Friday 13 February** using the below table. The document should act as a method of detailing any confidential marking inaccuracies found and how they should be corrected.

All confidential information should be underlined, and information that is submitted as 'confidential' [CON] should be highlighted in turquoise and all information submitted as 'depersonalised data'[DPD] in pink.

Issue 1 Unclear statements

Description of problem	Description of proposed amendment	Justification for amendment	EAG response
Page 3: "No additional data was provided to justify the choice either from the MIRASOL trial (where the Committee requested an	Proposed amendment: "No additional data was provided to justify the choice either from the MIRASOL trial **(where all data cuts had been provided as requested**	Please clarify that the MIRASOL trial is complete and all available data cuts had been provided previously.	Added clarification: "The company has stated that the MIRASOL trial is complete and no

additional data cut if available)"	**and no further data cut were available)** or from the literature where the company did not find any data of longer length for chemotherapy than that available in MIRASOL."	The current wording suggests the MIRASOL study is ongoing and that an additional data cut was available.	additional data cuts will be available in the future."
Page 4: "The EAG agrees that chemotherapy shows a consistently increasing trend within the MIRASOL trial. This is in line with multiple curve choices available for chemotherapy including the gamma and Weibull curves. The EAG, however, note that ~~**data from MIRASOL are not complete and that**~~ data within SACT indicates that a profile of decreasing hazards in the longer term could be expected.	Please amend to: "The EAG agrees that chemotherapy shows a consistently increasing trend within the MIRASOL trial. This is in line with multiple curve choices available for chemotherapy including the gamma and Weibull curves. The EAG, however, note that data within SACT indicates that a profile of decreasing hazards in the longer term could be expected."	For accuracy. The MIRASOL study is complete and concluded, and the sentence could be misinterpreted as otherwise.	Not all events were observed in MIRASOL and therefore the data is not complete. Have amended to state: "The EAG, however, note that not all patients in the chemotherapy arm had died when the trial was completed"
Page 4: "**The draft guidance actually says**: "They said that it was difficult to predict the long-term survival of people having mirvetuximab,	Please amend to: **The draft guidance adds further context**: "They said that it was difficult to predict the long-term survival of	The current wording potentially implies that the company did not accurately	Removed the word actually.

but it was plausible that about 10% could live beyond 5 years. This was because of mirvetuximab's novel mechanism of action.""	people having mirvetuximab, but it was plausible that about 10% could live beyond 5 years. This was because of mirvetuximab's novel mechanism of action."	reflect the wording in the DGD.	
Page 5: "The EAG note that eliciting survival in the manner conducted does not align with NICE recommendations to use structured methods (NICE manual 2022[5]) and is likely to cause bias in the estimates received."	Please clarify that the NICE methods says: Expert elicitation may use either structured or unstructured methods. The manual says both structured and unstructured methods is subject to risk of bias and high uncertainty, but structured are *preferred* as they attempt to minimise biases.	For clarity.	Amended to: "The EAG note that eliciting survival in the manner conducted does not align with NICE manual preference for use of structured methods (NICE manual 2022[5]); and is likely to cause increased bias in the estimates received."
Page 8: "SACT data shows that median survival was overestimated but long-term survival was underestimated for chemotherapy"	Please amend to: SACT data **suggests** that median survival was overestimated **in MIRASOL** but long-term survival was underestimated for chemotherapy	For clarity.	Amended
Page 11: The BGCS considered that patients with mirvetuximab would be expected to have better quality of life due to	Please amend to: The BGCS considered that patients with mirvetuximab would be expected to have better quality of life due to increased response rate, **and**	Please remove the statement that this did not reach statistical significance, as the response rate was statistically significant as reported in the	Removed note about statistical significance.

increased response rate, ~~although acknowledging this did not reach statistical significance.~~	**considered mirvetuximab to provide a substantial benefit for this disadvantaged group of women.**	submission, and this is therefore inaccurate and could lead to misunderstanding. Additionally, for completeness the full sentence from BGCS should be included.	
Page 15: "If outcomes in clinical practice are expected to be worse in the NHS than in MIRASOL this would be expected to be the case for both arms of MIRASOL"	Proposed amendment: "If outcomes in clinical practice are expected to be worse in the NHS than in MIRASOL **it is assumed this could** be the case for both arms of MIRASOL"	Please clarify that this is an assumption and cannot be validated.	This is the opinion of the EAG and not a factual inaccuracy.

Issue 2 Reporting of survival curves

Description of problem	Description of proposed amendment	Justification for amendment	EAG response
Page 8: Figure 4 shows extrapolations of the mirvetuximab and chemotherapy arms of MIRASOL that do not reflect those used in the company base case in the Excel model.	Update Figure 4 to reflect the overall survival curves used in the company base case in the Excel model.	For accuracy of reporting.	Thank you for flagging. Amended

For example, in Figure 4, extrapolated survival in the chemotherapy arm at 2 years is approximately 5% and survival in the mirvetuximab arm is approximately 20%. In the cost-effectiveness model (under the company base case), survival at 2 years is 20% for chemotherapy and 35% for mirvetuximab.			
Page 9: Figure 5 shows the log-logistic extrapolation of the chemotherapy arm of MIRASOL, but this does not reflect the Excel model.	Update Figure 5 to reflect the log-logistic curve for chemotherapy as used in the Excel model.	For accuracy of reporting.	Thank you for flagging. Amended
Page 9, Figure 5: the graph does not include a legend	Update graph to include legend.	For clarity.	Added

Issue 3 Reporting of model results

Description of problem	Description of proposed amendment	Justification for amendment	EAG response
Page 25, Table 2: costs and QALYs are reported incorrectly for the final two scenarios in the table (i.e. costs and QALYs have been switched for mirvetuximab and chemotherapy)	Update the reported costs and QALYs to reflect the relevant comparators.	For accuracy of reporting.	Amended
Page 18: The results of the EAG scenario analysis referenced in Section 1.5 ("The EAG retains an assumption of 0% vial sharing in the revised EAG base case and tests scenarios of 25% and **50%**") is missing from Table 2.	Please add the scenario analysis results assuming 50% vial sharing to Table 2 (EAG scenario analysis referenced in Section 1.5).	For accuracy of reporting.	Added

Issue 4 Typographical issues

Description of problem	Description of proposed amendment	Justification for amendment	EAG response
Page 5: “For chemotherapy the Weibull was considered by the company to provide a better fit to the **smoother** hazard plot”	Please amend to: “For chemotherapy the Weibull was considered by the company to provide a better fit to the **smoothed** hazard plot”	For accuracy.	Amended
Page 11: “The utility regression including treatment **interact** effect does not have face validity as the post-progression utility gain is much higher than pre-progression”	Please amend to: The utility regression including treatment **interaction** effect does not have face validity as the post-progression utility gain is much higher than pre-progression	For accuracy.	Amended

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]: A Single Technology Appraisal

EAG response to draft guidance consultation

6 February 2026

Produced by	Peninsula Technology Assessment Group (PenTAG) University of Exeter Medical School
Authors	Jemma Perks[1] Ahmed Abdelsabour[1] Charlotte Kelman[1] Sophie Robinson[1] Kate Scatchard[2] John A. Green[3] Sophia N. Karagiannis[4] Caroline Farmer[1] Dawn Lee[1] [1] Peninsula Technology Assessment Group (PenTAG), University of Exeter Medical School, Exeter [2] Royal Devon University Hospitals NHS Trust [3] Department of Health Data Science, University of Liverpool [4] King's College London
Correspondence to	Caroline Farmer 3.09 South Cloisters, St Luke's Campus, Heavitree Road, Exeter, EX1 2LU; c.farmer@exeter.ac.uk

Source of funding	This report was commissioned by the NIHR Evidence Synthesis Programme as project number NIHR175323.
Declared competing interests of the authors	None

This response supplements the following EAG report: Perks, Abdelsabour, Kelman, Robinson, Scatchard, Green, Farmer, Lee. Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]: A Single Technology Appraisal. Peninsula Technology Assessment Group (PenTAG), 2025.

1. EAG CRITIQUE OF COMPANY RESPONSE TO THE DRAFT GUIDANCE

1.1. Overall Survival (OS) extrapolation for the mirvetuximab and pooled chemotherapy arms

The company maintains their original curve selection of log-logistic for mirvetuximab and Weibull for chemotherapy rather than the gamma selected for both arms preferred by the Committee and EAG.

No additional data was provided to justify the choice either from the MIRASOL trial (where the Committee requested an additional datacut if available) or from the literature where the company did not find any data of longer length for chemotherapy than that available in MIRASOL. The company has stated that the MIRASOL trial is complete and no additional data cuts will be available in the future.

They justify this based upon:

1.1.1. Chemotherapy and mirvetuximab have substantially different mechanisms of action

Clinical expert opinion provided to the EAG was that they did not think the mechanism of action was different enough to justify a different long-term survival profile. They considered that the monoclonal antibody is just delivering a chemotherapy drug into an ovary cancer cell which then acts like all other cytotoxics to cause DNA damage triggering cell death. Whilst there is some pre-clinical evidence[1] that having a monoclonal antibody stuck to a cell surface could have an impact on highlighting that cell to the immune system for destruction which could potentially prolong the benefit of an anti-drug conjugate by promoting an immune response to the cancer cells they were not aware of any clinical data on the magnitude of this effect. Overall, the EAG concludes that there is no strong evidence either way.

1.1.2. Observed hazards following different trends

Mirvetuximab shows an increase followed by stabilisation and then increase when few patients remain at risk. The EAG notes the increase starts at ~120 weeks when 46 patients remained at risk which the EAG considers sufficient to be interpretable – a rule of thumb often used is 10 – 20% remaining at risk based upon Pocock 2002[2] which is 23 – 56 patients in the MIRASOL trial. This means that the increase in hazards at the end of the dataset cannot be ruled out as representing accurately expectations for mirvetuximab. The EAG note that none of the curves

submitted by the company accurately capture a profile of increasing hazards initially, decreasing hazards for the mid-point of the data and then increasing hazards at the end.

The EAG agrees that chemotherapy shows a consistently increasing trend within the MIRASOL trial. This is in line with multiple curve choices available for chemotherapy including the gamma and Weibull curves. The EAG, however, note that not all patients in the chemotherapy arm had died when the trial was completed and that data within SACT indicates that a profile of decreasing hazards in the longer term could be expected (see Section 1.1.9).

1.1.3. The gamma curve not allowing for as much flexibility in capturing the trends in the hazards as the log-logistic

The EAG note, as above, that the log-logistic does not allow for capture of the trend observed in the trial which appears to have two turning points and that the company has not submitted any new analysis with more flexible models such as those in TSD21[3] which could account for this.

1.1.4. That the impact of increasing age would not outweigh the mortality expected due to PROC

The hazard of general population mortality crosses that of death at 22 years when less than 1% of the population remains alive and this is accounted for within the economic model. The EAG agrees this is the case but note that the modelling of mortality due to age is not conducted in an ideal fashion as the model assumes all patients have the same starting age, whereas the trial includes patients with a distribution of starting ages

1.1.5. The log-logistic only becomes a poor visual fit to the mirvetuximab curve at around 36 months after the numbers at risk fall below a level that is interpretable

The EAG agrees with this but notes that the NICE TSDs (14[4] and 21[3]) place a greater weight on long-term plausibility than on visual fit to trial data.

1.1.6. Clinical expert plausibility

The company state that clinical experts at the Committee meeting said “it was plausible that about 10% could live beyond 5 years. This was because of mirvetuximab’s novel mechanism of action.” The draft guidance says: “They said that it was difficult to predict the long-term survival of people having mirvetuximab, but it was plausible that about 10% could live beyond 5 years. This was because of mirvetuximab’s novel mechanism of action.”

The EAG note that eliciting survival in the manner conducted does not align with NICE manual preference for use of structured methods (NICE manual 2022[5]); and is likely to cause increased bias in the estimates received. The EAG was not able to conduct a structured expert elicitation in the time available for AC response (< 2 weeks) but notes that the company could have.

The EAG's clinical expert also considered that it was difficult to estimate long term survival but that they would not expect the largest benefit to survival to be post-progression (see Section 1.1.7). Given the completeness of the PFS data there is little uncertainty regarding PFS.

Clinical expert input received from the BGCS in response to the draft ACD indicates that the expected length of life for women after the onset of platinum resistance is 9-12 months[6] (median). This is in line with the data submitted by the company, however, within broader literature it is clear that outcomes within PROC are heterogeneous[7] even with current treatments[8]. The BGCS's clinical expert considered that, based upon the trial data, they would expect a survival advantage of around 6 months over current treatments. This compares to the modelled mean undiscounted incremental life years of [redacted] months in the company base case and [redacted] in the revised EAG base case, [redacted]months using SACT data and log-logistic curve and hazard ratio from MIRASOL for mirvetuximab and [redacted]months when using SACT data for chemotherapy and gamma curve from MIRASOL for mirvetuximab.

1.1.7. Visual fit to the hazard plots for chemotherapy

For chemotherapy the Weibull was considered by the company to provide a better fit to the smoothed hazard plot (particularly in the earlier part of the data) and the distribution's landmark estimate of 0.8% at 5-years being optimistic in light of the 9-month median OS in clinical practice (versus 0.3% for the Weibull)

The EAG considers that there is little difference between curves in terms of visual or statistical fit, that the 5-year landmark fits with clinical expert advice received by the EAG better and that the median OS in a different study is not relevant to assessing expected 5 year survival in the MIRASOL population.

1.1.8. The EAG's key concerns around plausibility of long-term treatment effect and implausible post-progression survival gains remain unaddressed

The EAG notes that the key concerns of the EAG have not been addressed in the company's response. Namely that the company's base case assumed a continued improvement in the

hazard ratio favouring mirvetuximab over time (Figure 1). The EAG considered that this assumption was implausible.

Figure 1: Treatment effect over time: company base case, using RPSFTM adjusted data

Note: Figure and data can be found in Effectiveness_Calc sheet of the company's model.

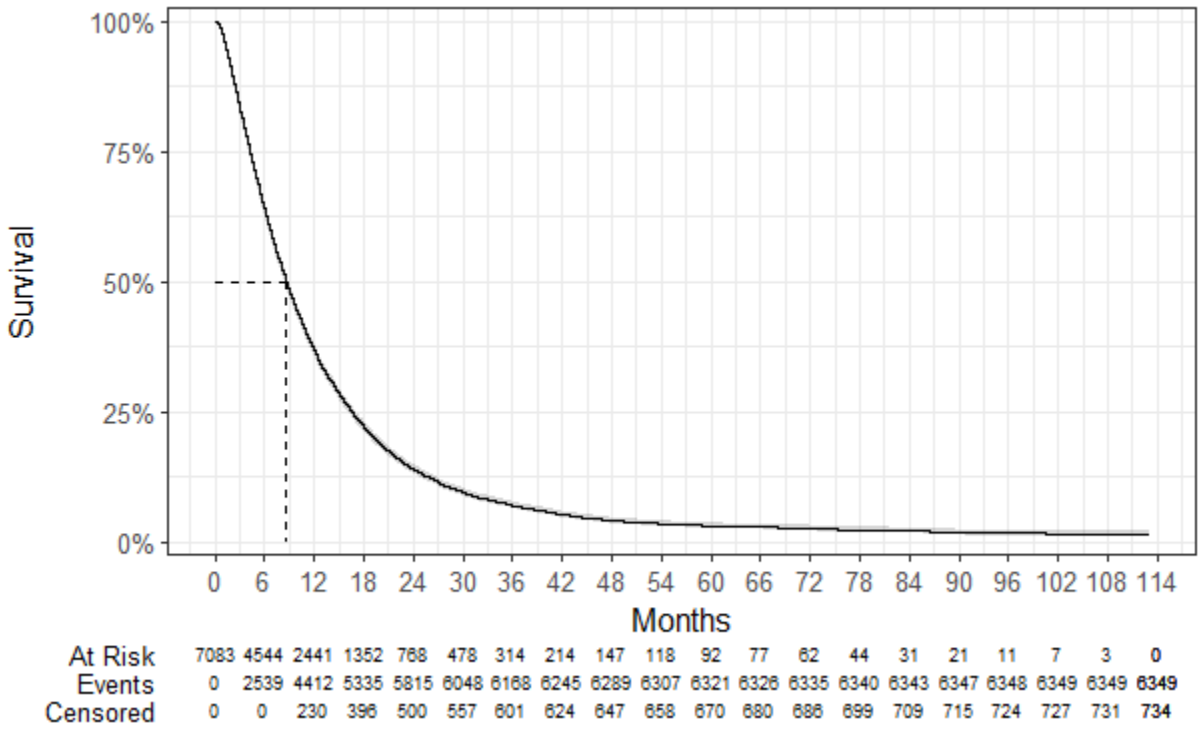
In addition, while the EAG accepted that some post-progression benefit from prior treatment with mirvetuximab may be plausible, it was not convinced that this could explain close to [redacted] the incremental gains in PPS ([redacted]) compared to the PFS benefit ([redacted]). This raised concerns that the model may be overestimating the true impact of mirvetuximab on survival.

1.1.9. SACT data suggests that median survival was overestimated in MIRASOL but long-term survival was underestimated for chemotherapy

Aggregate-level SACT data was provided to the EAG by NICE to inform long-term survival for chemotherapy. The median survival for PLD or paclitaxel in practice based upon data from 7,083 patients in SACT was lower than the observed median in the MIRASOL trial (8.64 vs 13.3 months). The Kaplan Meier curves exhibited a pattern of steep initial hazards followed by a

slowing in the long-term hazard with some patients remaining alive at 9 years (Figure 2). The restricted mean survival time was 14.2 months.

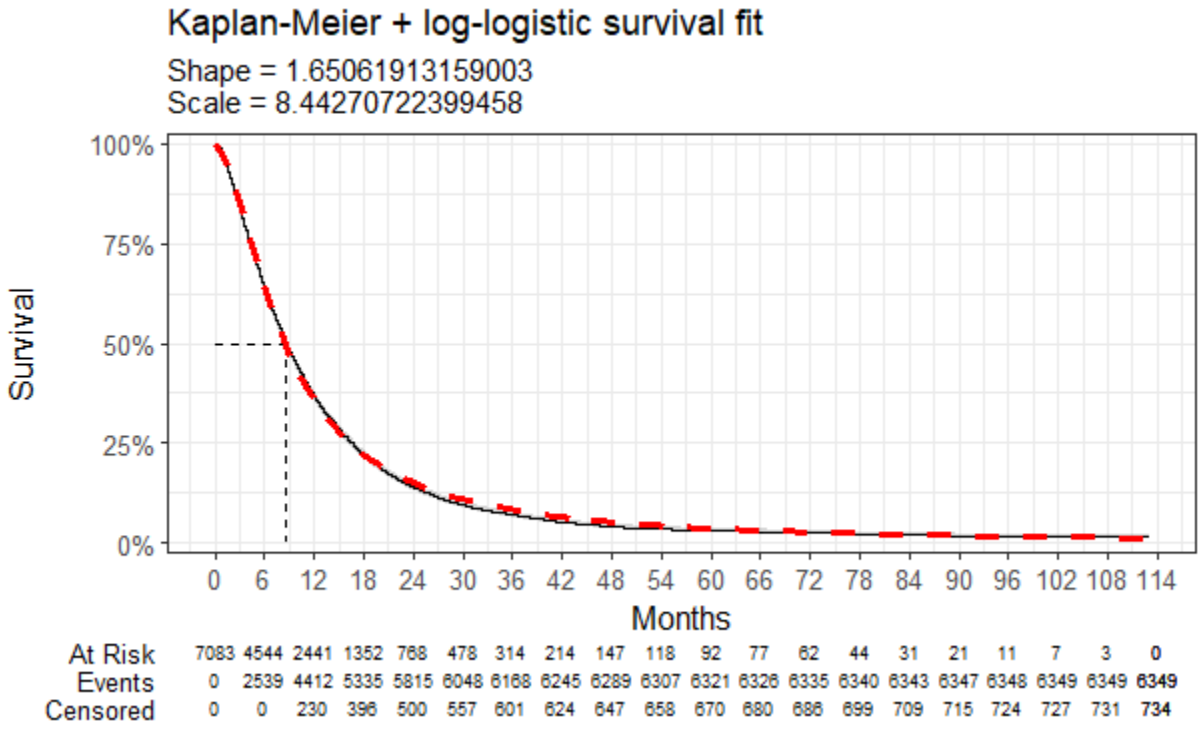
Figure 2: Overall survival amongst patients who have received PLD or paclitaxel monotherapy for PROC, SACT



The log-logistic curve provided the best statistical fit to the SACT data (Figure 3) and a good visual fit indicating that in the long-term curves which allowed for a decrease in hazards are likely to be most appropriate.

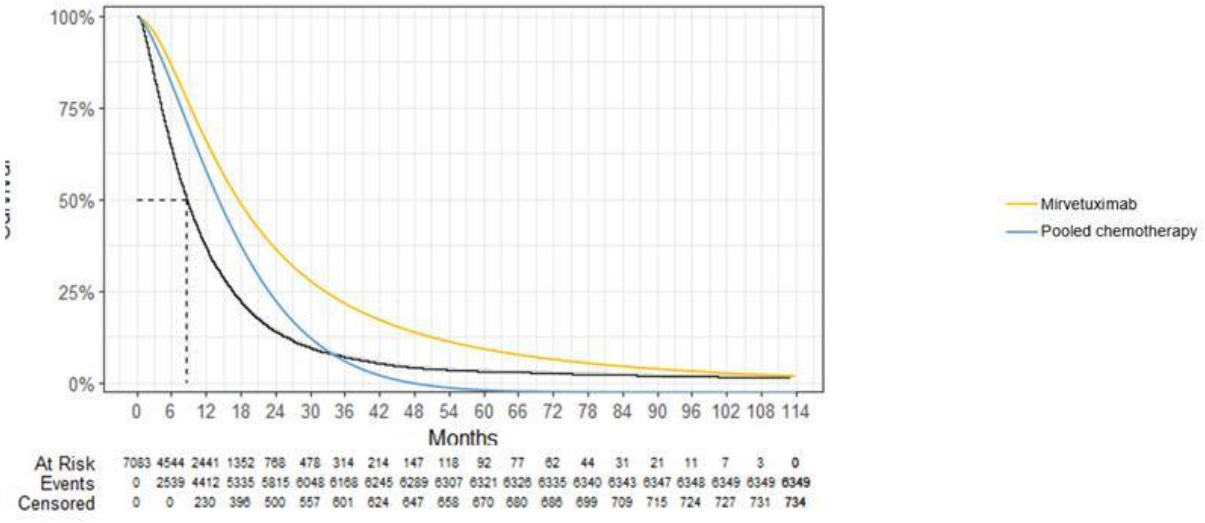
Figure 4 shows that the companies modelled projections considerably underestimated observed survival within SACT in the long-term for chemotherapy. The log-logistic curve applied to the MIRASOL data provided the closest fit to the trends in the observed SACT data in the longer term, along with being the best fit to the SACT data (Figure 3 and Figure 5).

Figure 3: Log-logistic curve fit to SACT data



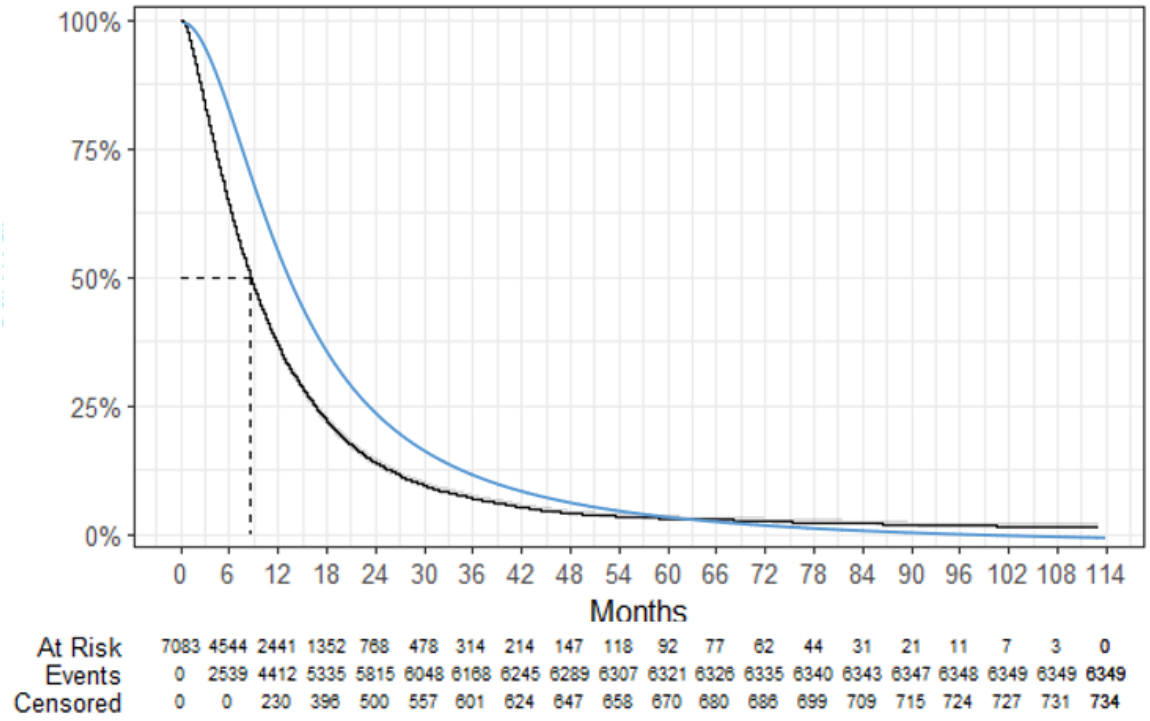
Notes: Dashed red = modelled SACT chemotherapy log-logistic, Black = SACT chemotherapy Kaplan Meier

Figure 4: Comparison of SACT to model projections



Notes: Orange = modelled mirvetuximab log-logistic, Blue = modelled chemotherapy Weibull, Black = SACT chemotherapy

Figure 5: Comparison of SACT to model projections, log-logistic curve



1.1.10. Revised EAG base case

The EAG's preference would have been to update the model to use SACT data to model outcomes for chemotherapy as this represents the data most generalisable to outcomes in UK practice and comes from a large sample size with long-term follow-up. The EAG was not, however, able to implement this for two reasons:

- Proportional hazards could not be considered a reasonable assumption within the trial and the EAG did not have access to MIRASOL trial data estimate time-dependent hazard ratios to apply to the SACT data
- SACT data is not available for PFS and is unclear what assumptions should be made to account for the difference in OS between MIRASOL and SACT to adjust PFS data

As the next best solution, the EAG base case was updated to use the log-logistic curve for both treatment arms. This provides the best fit to the SACT data for chemotherapy, provides a

reasonable fit for mirvetuximab and maintains the principle of assuming the same long-term survival profile for both treatments unless there is good reason to assume otherwise.

Figure 6: Treatment effect over time: EAG revised base case, using RPSFTM adjusted data

The EAG provides the following scenario analyses to test model sensitivity:

- Application of the log-logistic curve from SACT data with the hazard ratio of 0.68 from MIRASOL applied; this scenario is combined with the use of the mean age from SACT within the model (67) to provide an indicative assessment of what expectations might be in practice
- Naïve comparison - use of the gamma curve for mirvetuximab and log-logistic from SACT for chemotherapy

1.2. Health Related Quality of life (HRQoL) of patients on chemotherapy

1.2.1. The utility regression including treatment interaction effect does not have face validity as the post-progression utility gain is much higher than pre-progression

The company accepted the limitations of the vignette originally submitted for chemotherapy quality of life from Havrilesky et al and updated their approach to include use of utility analysis including an interaction term between treatment and progression from the MIRASOL trial and in addition to this disutilities for adverse events.

The company justified the use of the utility regression including the treatment interaction effect as being of a similar statistical fit and more accurately representing the differences they expect between treatment arms due to side effects.

The expectation that there would be a difference in quality of life whilst on treatment matches with stakeholder input on the differences in impact from adverse events and increased response to treatment.

The BGCS considered that patients with mirvetuximab would be expected to have better quality of life due to increased response rate. They considered that the benefit to quality of life may have been underestimated.

Clinical expert advice to the EAG is that they would expect an improvement in quality of life whilst progression free due to reduced treatment-related toxicity and delaying time to needing further chemotherapy.

OCA provided responses from a survey of people who had been impacted by ovarian cancer. Of six respondents who had had experience of both mirvetuximab and chemotherapy 5 considered mirvetuximab to offer better quality of life, one considered chemotherapy to offer greater quality of life. In addition, they provided information from patients who had only experienced chemotherapy on the key areas of impact and information from 7 patients who had taken mirvetuximab. Comments did indicate greater quality of life while taking mirvetuximab but that there were still impacts from side effects which impact quality of life e.g.: "*I have found my recovery time between treatments is so much quicker, giving me 2 weeks out of 3 of feeling like myself and wanting to get out and do things vs the traditional chemo it was the reverse, 2 weeks of feeling not like yourself and maybe 1 week of 'normal."*

The original utility regression which did not include the treatment interaction effect produced a small difference of ~0.03 between treatment arms both pre- and post-progression. The regression including the treatment interaction effect results in a smaller difference of ~0.02 pre progression and a much larger difference of ~0.08 post progression.

The EAG agrees that there is no meaningful difference in goodness of fit to the observed data between the two regressions based upon the statistical analysis provided by the company in their response.

The EAG does not agree that the updated regression provides greater face validity as, the lower increase in utility pre-progression is not in line with clinical and patient expert expectations that the majority of the benefit would be experienced whilst on treatment / pre-progression due to reduced side effects and delayed additional lines of treatment. It would appear difficult to justify the large difference post-progression (nearly 4 times greater than pre-progression) even accounting for a median increase in PFS2 of ~3 months and a ≤15% increased chance of response to subsequent chemotherapy as estimated by the company.

The EAG note that concerns raised in relation to the regression model including the treatment interaction effect in the EAG report were not addressed by the company namely that the unexpected direction of results i.e. more benefit post rather than pre-progression “may have been influenced by low sample size and high levels of missingness post progression.” The mixed model for repeated measures (MMRM) method used by the company assumed data were missing at random (MAR), but no justification for this assumption was given. Week 24 exhibits high levels of missing data, however, the company did not perform sensitivity analyses to explore the impact of this missingness. Consequently, it remains unclear to the EAG whether the MMRM model is appropriate under the MAR assumption.

The EAG notes that the Committee also considered that large differences post-progression would be difficult to justify, commenting in the draft guidance: “the company’s approach lacked face validity because of the large difference in the mirvetuximab post-progression utility and the pooled chemotherapy pre-progression utility.” Clinical expert advice to the EAG was also that this lacked face validity.

The company provided a scenario analysis differentiating utilities between first progression and the time spent after this. The company state that “expert opinion suggests that the utility between the first and second progression would be equal to the pre-progression chemotherapy

utility from MIRASOL. This is because these patients receive the same treatments (e.g. paclitaxel, pegylated liposomal doxorubicin) post progression, which are currently the only options in this patient population." The EAG agrees with the logic that quality of life will be , at least partly, dependent upon the type of treatment being received and note that the same treatments are available post chemotherapy and therefore a large differentiation in post progression utilities is unlikely to be justifiable. The EAG also notes that the company could have re-analysed their trial data to identify whether the utility values available post progression were pre or post second progression and therefore potentially used trial data for this analysis rather than making assumptions.

1.2.2. The disutility estimates included for alopecia may be too high as they assume all patients experience full hair loss on chemotherapy

The disutilities implemented by the EAG on top of the trial data were widened by the company to include alopecia. The utility value used was taken from NICE TA958 (ritlecitinib for treating severe alopecia areata[9]) based upon the difference between the best and worst health states and implies a greater impact for alopecia than for Grade 3+ adverse events including neutropenia and thrombocytopenia). The company did not justify selection of this source and did not present a full list of potential alternatives. The EAG note that there was considerable uncertainty during TA958 as to what the most appropriate utility values to use were.

Clinical expert advice to the EAG was that hair loss has a substantial impact on many patients due to the impact on body image and that paclitaxel causes full hair loss although with weekly scheduling it falls out quite slowly and that scalp cooling can be partially successful in preventing hair loss where this is available. They also noted that PLD generally only causes very mild hair thinning.

The overall impact of the inclusion of adverse events on top of the regression analysis including the interaction term was to increase the QALY difference between the two arms from [redacted] to [redacted].

As noted previously by the EAG there is the potential for double counting when applying the AE disutilities on top of values from MIRASOL, as some AE impact may already be captured in the treatment covariate.

1.2.3. Revised EAG base case

Given the advice received by the EAG and the lack of face validity of the large utility benefit post progression the EAG uses the original regression analysis without the treatment interaction effect in its base case. The EAG includes the disutility for alopecia as per the company base case for patients receiving paclitaxel but assumes a lower decrement (0.05 rather than 0.12) for patients receiving PLD in line with the values for moderate alopecia in TA958[9].

The EAG also provides scenario analysis testing the impact of assuming larger gains in utility for mirvetuximab pre-progression (0.05 and 0.10) and removing the additional AE disutilities to demonstrate model sensitivity.

1.3. Age

The BGCS provided audit data which showed that the average age of patients diagnosed with ovarian cancer is 66.3 years, they considered that people with platinum resistance would on average be 1 – 2 years older than this.

Data from 7,083 patients in SACT indicated that the mean age of patients who received PLD or paclitaxel at the start of treatment for PROC was 67, median 68, which is in line with the above.

This is older than the mean age of patients in the MIRASOL trial (62.8). The impact of using the mean age from SACT is tested in EAG scenario analysis, however, as noted previously a difference in the age of patients in the trial compared to practice would be expected to impact on outcomes for both mirvetuximab and chemotherapy.

1.4. Severity modifier

The company argues that the 1.7 x severity modifier should apply for a number of reasons:

1.4.1. Survival in NHS clinical practice is lower than in MIRASOL

The company provide two additional data sources for chemotherapy outcomes outside of MIRASOL one of which is the real-world outcomes of a cohort of patients with PROC treated at the Edinburgh Cancer Centre[10]. The method used to identify these sources was not provided and therefore the EAG cannot be certain that no other data were available.

The company state that as the median OS was lower than the chemotherapy arm in MIRASOL then this data should be used to calculate the severity modifier. The EAG agree that the

modelled survival for chemotherapy should accurately reflect what is expected in NHS practice. This should be the case both for calculation of the severity modifier and for outcomes included in the cost-effectiveness analysis.

Information available from SACT indicates a median OS of 8.6 – 8.7 months for PROC for patients receiving PLD or paclitaxel (there was minimal variation dependent upon the definition used to capture PROC).

If outcomes in clinical practice are expected to be worse in the NHS than in MIRASOL this would be expected to be the case for both arms of MIRASOL (as it is likely driven by factors such as differences in demographics e.g. age and follow-up frequency). This should be accounted for in the economic analysis. The EAG provide scenario analysis which shows the potential impact of this in a simplistic manner using SACT data as discussed in Section 1.1.10. This maintains the treatment effect seen in the trial which aligns to guidance provided in the NICE manual and prior appraisals:

“Quantifying the baseline risk of health outcomes and how the condition would naturally progress with the comparator(s) can be a useful step when estimating absolute health outcomes in the economic analysis. This can be informed by observational studies. Relative treatment effects seen in randomised trials may then be applied to data on the baseline risk of health outcomes for the populations or subgroups of interest.” NICE manual 2022[5]

“Specifically, the committee thought that using randomised data to estimate absolute event rates runs the risk of results that do not reflect NHS practice. It also thought that using observational data to estimate relative effects runs the risk of biased treatment effects because of unadjusted confounding variables. The committee noted that NICE’s technical support document 13 makes this distinction, advocating registry data to estimate absolute baseline event rates and randomised evidence to quantify relative differences. The committee concluded that it still preferred using the real-world evidence to estimate survival for people having cabazitaxel and the network meta- analysis to estimate the relative treatment effect of cabazitaxel compared with lutetium-177.” TA930[11]

1.4.2. The utility values in MIRASOL do not fully capture the poor quality of life of patients on chemotherapy

The EAG do not consider that the company has demonstrated this. Particularly as the data available for MIRASOL aligns to previous trial data (TA389[12]) and both the EAG and company

implement additional decrements for quality of life for adverse events on top of health state utilities which risks some double counting.

The company argue that they were unable to fully capture the differences in quality of life between treatments in MIRASOL. The EAG is unclear as to whether this is due to the nature of the condition or whether this was due to trial design choices made by the company.

1.4.3. PROC is a severe underserved disease area

The EAG agrees that this is the case, however, the NICE manual[5] states that the degree of severity should be assessed based upon the absolute and proportional shortfall of current established practice rather than qualitative arguments around severity and unmet need.

1.4.4. Impact on caregiver quality of life was not captured

Clinical experts to the EAG considered that the impact on carers would differ according to time within the chemotherapy cycle (with the worst impact being in the first week of the schedule) and stage of disease (with most patients able to function reasonably well until late-stage disease).

Evidence supplied by the company indicates that 50% of survey respondents to an Adelphi Real World Evidence Survey in Canada, France, Italy, Spain and the UK require some additional support/care (177 – 89 with no requirements out of 177 where the type of care was known); and 11% had a professional rather than informal caregiver. Full details of this study were not provided. Usual practice Adelphi Disease Specific Programmes is to survey physicians rather than patients or caregivers and therefore the source (and representativeness) of this data is unclear. Of the 88 who did require some support only 43 were able to provide an estimate of the time required, which indicates a high level of missingness which may not be at random.

Given the above the EAG estimates that 39% of patients have an informal caregiver but notes that this estimate is subject to considerable uncertainty.

Pennington et al provide an approximate relationship between quality of life decrease for patients and caregivers (0.12 QALYs lost for caregivers for every 1 QALY lost for patients[13]) based upon data for coresident carer and care-recipient dyads from the UK Household Longitudinal Survey (n = 1,072 carers) using the SF-12 mapped to EQ-5D. Based upon this an additional incremental QALY loss of [redacted](39% carers)[redacted](100% carers) is assumed in the chemotherapy arm.

1.4.5. The EAG QALY shortfall is close to the threshold of 0.95

The EAG provides the QALY shortfall information for the Committee for decision making in the results provided.

1.5. Vial sharing

The Committee considered that vial sharing was unlikely to be achievable on the basis of input from NHSE. The company considered this was inconsistent with comparable appraisals (TA862[14]) and stated that feedback from NHS pharmacists and consultants that AbbVie consulted was that patients with PROC are frequently scheduled for treatment on specific days of the working week, therefore, the opportunity for substantial vial sharing is enhanced.

The EAG contacted NHSE to obtain further data on the use of trastuzumab deruxtecan to check whether patient numbers were comparable. NHSE stated that there are two indications in which this product is used:

- Trastuzumab deruxtecan for treating HER2-positive unresectable or metastatic breast cancer after 2 or more anti-HER2 therapies (TA704[15])
- Trastuzumab deruxtecan for treating HER2-positive unresectable or metastatic breast cancer after 1 or more anti-HER2 treatments (TA862[14])

Across both indications the number of treated patients is approximately 600 and they are treated for around 18 months on average with treatment given once every 3 weeks.

Based upon the predictions supplied by the company for mirvetuximab in their budget impact analysis the company estimated that mirvetuximab would be used to treat [redacted] patients in year 1 rising to [redacted] by year 3 and[redacted] by year 5 with a modelled time on treatment of [redacted] weeks in the company base case ,and [redacted] weeks in the EAG revised base case (i.e. ~ [redacted] months) with treatment given once every 3 weeks.

Clinical expert advice to the EAG was also that the population suitable for trastuzumab deruxtecan is larger as it is also used in other indications including lung, gastric cancers that express HER2 and ovarian cancer.

Given the considerably longer time on treatment expected for trastuzumab deruxtecan this leads to there being more than [redacted] times more patients being expected to be treated with

trastuzumab deruxtecan than mirvetuximab. It therefore cannot be stated that the patient population sizes are similar and that vial sharing assumptions should be the same on the basis of precedent.

The EAG's clinical expert advisor did not consider that there would be much scope for in-house vial sharing as typically only 1-2 patients would be receiving mirvetuximab at any time so there would be a low chance of aligning them to the same day. They did consider that vial sharing would be more feasible for hospitals which are using outsourcing companies as they would be more likely to be able to constitute multiple doses at the same time.

The EAG retains an assumption of 0% vial sharing in the revised EAG base case and tests scenarios of 25% and 50%.

1.6. Relative dose intensity

The company prefers to model the RDI as an average value across all timepoints and state that the reason the EAG requested exploration of time dependency was due to concern about the potential that patients who tolerate the full dose better remaining on treatment longer. This is correct that this was part of the EAG's concern. The other part of the concern was that wastage around reduced doses may not have been appropriately handled. This remains a concern.

The mean RDI used in the company model is [redacted] This is higher than the long-term RDI used for mirvetuximab in the cycle-specific analysis ([redacted] after 28 weeks). What drives the difference in cost-effectiveness is that in the earliest cycles where patient numbers are highest the trial observed RDI values are greater than the mean. The EAG therefore maintains that cycle-specific RDI values are more appropriate as these reflect fewer missed / reduced doses in the early cycles more appropriately.

1.7. Management of adverse events

The company prefers to maintain the use of a weighted average cost for anaemia and neutropenia rather than using the Committee's preference to assume that anaemia and neutropenia are managed as a day case. The weighted average is taken from NHS reference costs which reflects the average split across all types of diseases and is therefore not necessarily representative of chemotherapy side effects for PROC. The company justify this with precedent from prior OC appraisals. The EAG note that the NICE manual[5] clearly states that precedent does not constitute a rationale for choices in and of itself. The EAG also notes

that AE costs are not usually given a large amount of attention within NICE appraisals and also that the costs used in the prior TAs were in 5 out of 6 cases lower than the updated Abbvie base case.

Clinical expert advice to the EAG is that the vast majority of Grade 3+ for anaemia and neutropenia would be treated as a day case. They considered that only a very, very small proportion of anemia cases would require a blood transfusion outside of a day case setting. For neutropenia they stated they would only admit if the patient developed an infection whilst neutropenic i.e. febrile neutropenia/ neutropenic sepsis. There were [redacted] cases of serious febrile neutropenia in mirvetuximab arm and [redacted] in the topotecan arm of MIRASOL. Topotecan is not routinely used in England. Considering all grades of seriousness, there were [redacted] cases for mirvetuximab and [redacted] for topotecan. For neutropenic sepsis, there was [redacted] serious event in mirvetuximab arm and [redacted] for the chemotherapy arms. There were [redacted]. Given this the EAG maintains the assumption that for anaemia and neutropenia would be treated as a day case.

1.8. Mirvetuximab duration of treatment

The EAG maintains that use of the exponential distribution for the full-time horizon underestimates the proportion on treatment early in the modelled time horizon (Figure 7). A 120-week timepoint was selected by the EAG as very few patients remained at risk after this timepoint (n=[redacted]). Use of an earlier timepoint was initially considered, however, as no patients were censored for time on treatment in the dataset this was not considered appropriate.

Given that the data for duration of treatment were complete the EAG revised base case uses the Kaplan Meier data directly to avoid introducing additional uncertainty.

Figure 7: Duration of treatment by approach used

1.9. Subgroup analysis

The company did not submit additional data regarding the potential for a different treatment effect based on prior response to platinum chemotherapy. As also stated in the EAG report, the company highlighted the uncertainty in the subgroup analyses available from MIRASOL and FORWARD-1, meaning that it was not possible to robustly estimate the treatment effect in those with and without a primary platinum-free interval of 6-months. Given that the subgroup analysis for platinum-free interval showed a meaningful difference in treatment effect for OS in MIRASOL, and that clinical experts to the EAG suggested that there was a clinical rationale for this, the EAG still considered this to be an uncertainty in this appraisal, despite the inconsistencies and limitations of the subgroup analyses. As stated in the EAG report, cost effectiveness analysis of mirvetuximab according to platinum-free interval leads to a large increase in the ICER in both the company and EAG base cases.

1.10. Uncaptured benefits

1.10.1. Rarity of PROC

The company stated that PROC has been designated as a rare type of cancer and mirvetuximab was granted orphan designation by the European Medicines Agency (EMA) in

2015. As stated in the original EAG report. The company estimated in the CS that approximately 2,144 women in England develop epithelial HGS PROC each year. The company noted that rare diseases may present a challenge to reimbursement as key benefits to patients are not captured in economic modelling; specifically, the company re-stated that mirvetuximab offers a novel treatment option in this patient group and that the value of hope in providing a new treatment option should be considered as additional to the QALY gains associated with treatment.

Stakeholders to the appraisal noted that the availability of a treatment option for PROC does offer hope for patients, both for their own treatment as well as the treatment for others with PROC. As stated in the EAG report, the value of hope is not quantifiable within the NICE framework. However, stakeholders to the appraisal note that there is a need for innovation in the treatment of this patient group, where limited advances in treatment have occurred in recent years.

1.10.2. Caregiver burden

The EAG provides scenarios to demonstrate model sensitivity to the inclusion of caregiver burden.

1.10.3. Inequality in PROC

The company stated that the treatment schedule and side effects associated with chemotherapy may disproportionately affect some patient groups over others, thus creating inequalities in access to chemotherapy. They stated that mirvetuximab had an improved safety profile, which would result in more people continuing to receive treatment. As reported in the EAG report, the EAG found no meaningful difference in safety profile between mirvetuximab and chemotherapy from the CS; notably, 9% and 8% of participants in the mirvetuximab and chemotherapy arms of MIRASOL, respectively, discontinued treatment due to side effects. The EAG therefore did not consider there to be evidence that treatment with mirvetuximab would reduce inequalities related to access due to its safety profile.

The company stated that people with PROC from ethnic minority backgrounds and those who have language barriers may be disproportionately affected by the side effects from chemotherapy compared to those for mirvetuximab. The company offered no explanation for which side effects it considered to be relevant to this argument, and the EAG could find no evidence to substantiate it.

The company noted that as mirvetuximab requires fewer visits to receive treatment than paclitaxel, this would result in financial savings due to travel and time off work, which may particularly benefit those from low socioeconomic backgrounds. They also stated that “As mirvetuximab requires fewer visits than paclitaxel…. mirvetuximab may reduce the need for these patients to seek additional help or deal with AEs for long periods”. While the EAG agreed that fewer visits to receive treatment may be more acceptable to patients and offer some financial benefits, and this is supported by stakeholder submissions to the appraisal, the EAG noted that the company had not adequately presented evidence that mirvetuximab would be associated with reduced treatment burden for people with PROC. The EAG considered that this conclusion is not simple, given that treatment with PLD is associated with a lower frequency of treatment than mirvetuximab, and mirvetuximab is associated with a longer treatment duration (therefore more administrations over time). Moreover, the company has not demonstrated how impactful any variation in treatment regime would be to the lives of people with PROC over and above the QALY estimates already included in the analysis.

Finally, the company noted that people from Caribbean and African backgrounds and those who are older and from lower socioeconomic groups may be more likely to be diagnosed with ovarian cancer at a later stage. They therefore propose that the entry of a new treatment option for this population may benefit these groups. As stated in Section 1.10.1, there has been limited innovation in this patient population for some time.

2. REVISED EAG COST EFFECTIVENESS RESULTS

Table 1 presents the revised EAG base case. [redacted] In both the company and EAG base case the applicable severity modifier is x1.2 and the ICERs with this modifier [redacted] The changes to the company base case which had the most impact on the ICER were:

- Changing the overall survival curve for chemotherapy in MIRASOL to log-logistic based upon the curve fit which provided the best representation of the SACT data
- Using the utilities from MIRASOL without the treatment interaction effect

Table 2 presents scenarios around the revised EAG base case. The scenarios which had the greatest impact were:

- The inclusion of carer disutilities. These decreased the ICER by ~£[redacted]k when all patients were assumed to have an informal carer and ~£[redacted]k when 39% were assumed to have an informal carer in line with the survey data supplied by the company
- The method used for survival analysis:
    - Using the log-logistic curve fit directly to SACT data and assuming proportional hazards applied to derive the curve for mirvetuximab reduced the ICER by ~£[redacted]k. This is considered overly optimistic as proportional hazards did not apply in the trial.
    - Using the naïve comparison of log-logistic from SACT for chemotherapy + gamma from MIRASOL for mirvetuximab reduced the ICER by ~£[redacted]k

Assuming larger gains in pre-progression utilities did not have a meaningful impact on the ICER, even when assuming a large gain of 0.1 (reduction of ~£[redacted]k).

Table 1: Revised EAG base case

Preferred Assumption	Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER	Change in ICER vs co base case	Abs SF	Prop SF	Severity Modifier
Company base case	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
Cycle-Specific RDI	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
Duration of treatment using KM	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
No vial sharing	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
Chemotherapy OS: log-logistic	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.697	91.9%	1.2
Utilities from MIRASOL without treatment interaction effect	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
Adjust AEs costs	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
Disutility of alopecia treatment dependent	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
EAG base case	**Chemotherapy**	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	**10.697**	**91.9%**	**1.2**

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Table 2: EAG scenario analysis

Preferred Assumption	Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER	Change in ICER vs EAG base case	Abs SF	Prop SF	Severity Modifier
EAG base case	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.697	91.9%	1.2
Include carer disutility for 39% of patients	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.697	91.9%	1.2
Include carer disutility for 100% of patients	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.697	91.9%	1.2
Log-logistic from SACT chemotherapy+ HR from MIRASOL for mirvetuximab	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.403	92.4%	1.2
Log-logistic from SACT chemotherapy + gamma from MIRASOL for mirvetuximab	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.403	92.4%	1.2
Exclude AEs disutilities	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.697	91.9%	1.2
Assume 25% vial sharing	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.697	91.9%	1.2
Assume 50% vial sharing	Chemotherapy	[redacted]	[redacted]							
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.697	91.9%	1.2
Assume utility difference 0.05 pre-progression*	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.656	91.5%	1.2
Assume utility difference 0.10 pre-progression*	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]				
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.656	91.5%	1.2

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Notes: * Utility increase applied to mirvetuximab arm, independent effect of adverse events not included

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Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]: A Single Technology Appraisal

EAG response to Company addendum

March 2026

Produced by	Peninsula Technology Assessment Group (PenTAG) University of Exeter Medical School
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1. EAG CRITIQUE OF COMPANY ADDENDUM

1.1. Overall Survival (OS) extrapolation for the mirvetuximab and pooled chemotherapy arms

Following receipt of additional evidence from NICE in the form of a SACT dataset and the associated EAG analyses, the company accepted the EAG's conclusion that the log-logistic model provided the best fit to the SACT OS data.

The company expressed a preference from the analyses presented by the EAG for the scenario in which the hazard ratio from MIRASOL was applied to the SACT baseline curve to estimate survival for mirvetuximab. The company did not, however, apply this preference as their base case in the additional economic analysis submitted.

The EAG considers the use of SACT data with the hazard ratio from MIRASOL to be a valid approach. However, its appropriateness depends on the proportional hazards (PH) assumption holding. If the PH assumption is violated, applying a constant HR over time may result in biased survival estimates and, consequently, uncertainty in the cost-effectiveness results.

Visual inspection of the log cumulative hazards plot Figure 1 shows cumulative hazards cross in several places, and the distance between the curves changing over time. This suggests that the PH assumption may be inappropriate. The EAG note, however, that the gap between the two treatments remains relatively constant after initial crossing and that there is no evidence of the hazards trending towards each other which indicates that applying a constant HR to longer term estimates is unlikely to bias towards mirvetuximab.

The EAG notes that its base case estimate is closer to clinical expectations as the BGCS's clinical expert considered that, based upon the trial data, they would expect a survival advantage of around 6 months over current treatments. This compares to the modelled mean undiscounted incremental life years of [redacted] months in the company base case and [redacted] in the revised EAG base case, [redacted] months using SACT data and log-logistic curve and hazard ratio from MIRASOL for mirvetuximab and [redacted] months when using SACT data for chemotherapy and gamma curve from MIRASOL for mirvetuximab.

The EAG also notes that, despite the company stating a preference for incorporating SACT data using the MIRASOL hazard ratio described as more robust than excluding SACT entirely, the company's revised base case does not adopt this approach. The company base case is still

using independent parametric models (log-logistic for mirvetuximab and Weibull for chemotherapy), resulting in an ICER of [redacted] per QALY.

This corresponds to an incremental post-progression survival gain of [redacted] months in the company base case, [redacted] months in the revised EAG base case, [redacted] months when using SACT data with a log-logistic curve and applying the hazard ratio from MIRASOL for mirvetuximab, and [redacted] months when using SACT data for chemotherapy and a gamma curve from MIRASOL for mirvetuximab.

The EAG does not consider the magnitude of the post-progression gain in either the company base case or the scenario applying the HR to SACT data to hold face validity given that this is [redacted] times the gain observed pre-progression.

Figure 2 to Figure 4 show visually the predictions for each of the scenarios considered and Table 1 provides medians and landmark estimates. As can be seen in the plots the company prediction for chemotherapy is unrealistic as almost all patients are assumed to have died by [redacted] in the model whereas patients were observed to be still alive at this timepoint in the SACT dataset.

Figure 1: Log cumulative hazard plot for OS – mirvetuximab vs pooled chemotherapy

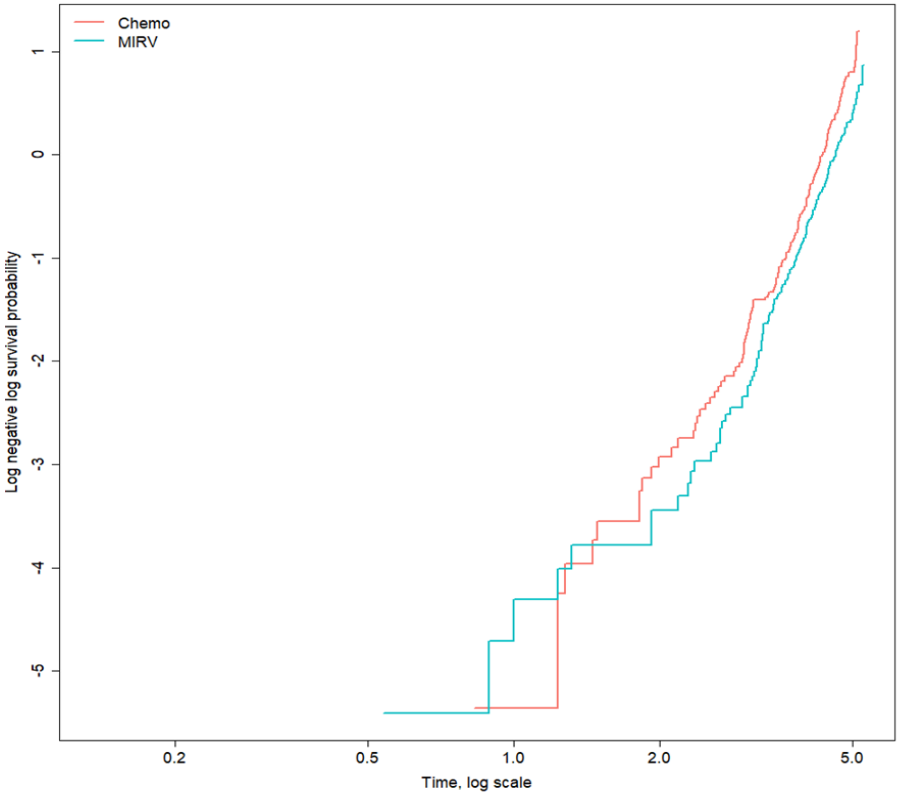


Figure 2: OS and PFS predictions SACT+HR

Blue = PFS chemo; yellow = PFS MIRV; green = OS chemo; red = OS MIRV.

Figure 3: Mirvetuximab OS

Figure 4: Chemotherapy OS prediction

Table 1: Landmark OS

Scenario	Treatment arm	Median OS (months)	1-year OS (%)	2-year OS (%)	3-year OS (%)	5-year OS (%)	10-year OS (%)
EAG revised base case	Mirvetuximab (MIRASOL log-logistic)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Chemotherapy (MIRASOL log-logistic)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Company revised base case	Mirvetuximab (MIRASOL log-logistic)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Chemotherapy (MIRASOL Weibull)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
SACT + HR from MIRASOL	Mirvetuximab (HR from MIRASOL applied to SACT)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Chemotherapy (SACT loglogistic)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

1.2. Utilities

The company provided additional analyses exploring the impact of missing data through the use of exploratory scenario analyses:

- A weighted average of utility values for patients who report pre-progression data and don't progress (censored or died), or patients who report post-progression data and patients who report pre-progression utility data (n=313 observations pre-progression and n=243 observations post progression), progress but don't report post progression data (n=91 observations pre-progression, assumption made that the treatment effect is the same pre and post-progression); patients with no data considered non-informative and excluded (n=20)
- As per the above except patients with no data were assumed to have equal utility values for mirvetuximab and chemotherapy pre- and post-progression

- As per the above except patients with no data were assumed to have the same utilities as patients who report pre-progression utility data, progress but don't report post progression data

In all 3 cases the difference in post-progression utility between mirvetuximab and chemotherapy was reduced compared to the company base case model (including the interaction term) – 0.080 vs 0.060 – 0.063. The pre-progression utility difference remained relatively stable 0.020 vs 0.018 – 0.019.

Whilst exploration of the model sensitivity to missing data by the company is welcomed the EAG does not consider the scenarios presented to be exhaustive of the possibilities in that they do not account for missingness across the length of follow-up for post-progression observations (it is likely that sicker patients are contributing less to the analysis in both arms with this effect being more prominent in the mirvetuximab arm due to increased survival).

The EAG notes that whilst the gap between pre- and post-progression utility differences between mirvetuximab and chemotherapy reduces in all the analyses presented compared to the company base case the issue of increased benefit post-progression remains. Increased benefit post-progression was not considered clinically plausible by the EAG's clinical experts.

1.3. Vial sharing

The EAG maintains its position, as the company has not adequately addressed the key points raised.

The EAG's central argument relates not simply to annual patient numbers, but to the number of patients on treatment at the same time, which is driven by time on treatment. trastuzumab has an average treatment duration of approximately 18 months, compared with around [redacted] for mirvetuximab. All else being equal, this means [redacted] the steady-state number of patients available for vial sharing at any given time for trastuzumab.

Although the company's clinical experts suggested there may be greater scope for centralisation in PROC, the EAG's clinical expert advised that meaningful vial sharing would be feasible only in larger hospitals, as they outsource aseptic preparation. The company has not provided quantitative estimates of how the expected patients per centre would differ in PROC to support 50% vial sharing. This point remains unaddressed.

Lastly, the fact that 50% vial sharing was accepted in TA704 when trastuzumab deruxtecan was appraised in its first indication does not in itself constitute evidence to support applying the same assumption here.

Based on this, the EAG retains an assumption of 0% vial sharing in the revised EAG base case and tests scenarios of 25% and 50%.

1.4. Baseline ocular assessments

The EAG notes that exclusion of the baseline ocular assessment cost would only be appropriate if there were clear evidence that the company-funded arrangement has been formally agreed and will apply for the full duration of branded drug availability within the NHS.

No evidence has been presented to demonstrate that such an arrangement is nationally implemented or guaranteed over the relevant time horizon. In the absence of this, the EAG considers it inappropriate to exclude the cost from the base case, as doing so risks underestimating the true cost to the NHS.

1.5. Carer disutility

The EAG does not accept the company's assumption that 70% of patients have an informal carer in the base case. This is not supported by an empirical data source and, moreover, it contradicts the only data source provided by the company (the Adelphi Real World Evidence survey), showing 39% of patients have informal carers. The company has not provided any rationale as to why the data they commissioned from Adelphi would underestimate the proportion of patients with an informal carer.

1.6. Administration cost

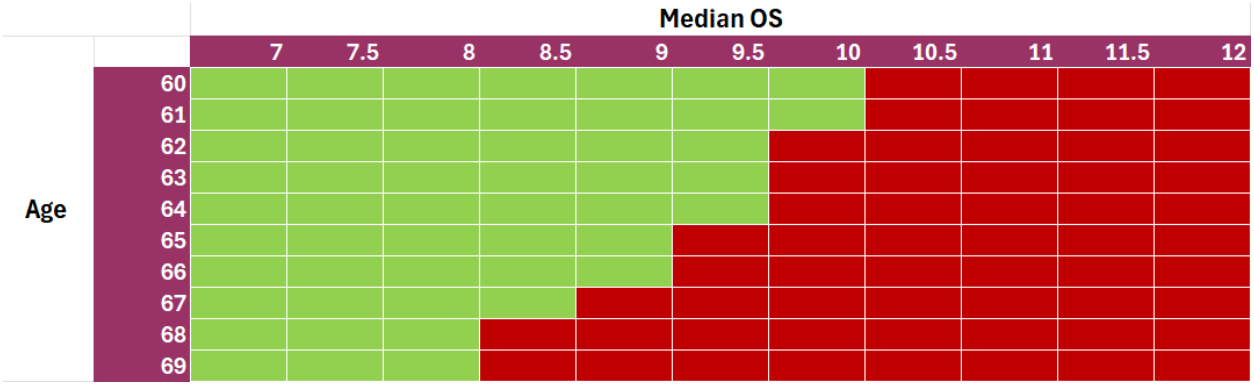
This issue was recently considered in the appraisal of tisotumab vedotin (ID3753). In that appraisal, the Cancer Drugs Fund clinical lead advised that the SB13Z cost code could be used for weekly paclitaxel, as it appropriately captures the time required to cannulate, administer premedication and paclitaxel, flush the line and remove the cannula.

Based on this the EAG accepts the change in the administration cost and incorporated it in its base case as it reflects established clinical view regarding the complexity of administration.

1.7. QALY shortfall

The company provided an analysis exploring the severity modifier based on combinations of median OS and age. However, previous NICE end-of-life appeals have determined that economic analyses should consider mean survival rather than median survival in line with general health economics principles which require capture of the distribution of outcomes for the whole cohort. The same principle applies to the calculation of proportional QALY shortfall, which is derived from modelled mean QALYs. The EAG therefore considers that analyses based on median OS are not appropriate.

Figure 5: Severity modifier analysis sent by the company



The estimated mean OS for chemotherapy ranges from [redacted] months (log-logistic model informed by SACT data) to [redacted] (log-logistic model based on MIRASOL), with [redacted] estimated using the company's Weibull model based on MIRASOL. These values are much higher than the median OS values explored in the company's scenario analysis. The EAG also notes that the 62.8 years mean age from MIRASOL, 66 years mean age at diagnosis reported in the National Ovarian Cancer Audit State of the Nation report (2025) and 69 years as the mean age of people starting first-line maintenance PARP inhibitor treatment in England, all fall within the upper part of the range considered.

Based on this the EAG considers that the company's scenario analysis does not provide sufficient numeric justification for applying the 1.7 severity modifier, and the 1.2 modifier remains appropriate under the preferred assumptions.

1.8. Revised EAG base case

Table 2 and Table 3 present the revised EAG and company base cases and additional scenario analysis using the 1.2 severity modifier. Table 4 presents the revised EAG and company base cases using 1, 1.2 and 1.7 severity modifiers and Table 5 Table 4 provides the calculation for the QALY shortfall for each. [redacted]

Table 2: Revised EAG base case

Preferred assumption	Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER (£/QALY)	Change in ICER vs company base case	Abs SF	Prop SF	Severity modifier
Revised company base case	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.30%	1.2
Revised company base case applying SCAT + HR	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.425	92.60%	1.2
EAG base case (accept admin change)	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.30%	1.2
EAG base case (accept admin change) + SACT + HR	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.403	92.40%	1.2

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Table 3: Additional scenario analysis

Scenario	Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER (£/QALY)	Change in ICER vs EAG base case	Abs SF	Prop SF	Severity modifier
70% informal carer	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
50% vial sharing	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2
25% vial sharing	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10.861	93.3%	1.2

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Notes: * Utility increase applied to mirvetuximab arm, independent effect of adverse events not included

Table 4: ICER by severity weight

	ICER		
	Severity modifier: 1.7	**Severity modifier: 1.2**	**No severity modifier**
Company revised base case	[redacted]	[redacted]	[redacted]
Company revised base case using SACT data +HR	[redacted]	[redacted]	[redacted]
EAG revised base case	[redacted]	[redacted]	[redacted]
EAG revised base case using SACT data +HR	[redacted]	[redacted]	[redacted]

Table 5: QALY shortfall and severity modifier calculations for company and EAG analyses

Analysis	QALYs of people without condition	QALYs with the condition on current treatment	Abs. QALY shortfall (years)	Prop. QALY shortfall (%)	Calculated QALY weighting
Company base case • 62.8 as starting age (MIRASOL) • Utilities MIRASOL with interaction term • Chemotherapy OS: MIRASOL Weibull	11.64	0.78	10.86	93.3%	x1.2
EAG base case • 62.8 as starting age (MIRASOL) • Utilities MIRASOL without interaction term • Chemotherapy OS: MIRASOL log-logistic	11.64	0.98	10.67	91.6%	x1.2
Company alternative preferred scenario analysis • 67 as starting age (SACT) • Utilities MIRASOL with interaction term • Chemotherapy OS: SACT log-logistic	10.18	0.75	9.42	92.6%	x1.2
EAG Scenario using SACT • 67 as starting age (SACT) • Utilities MIRASOL without interaction term • Chemotherapy OS: SACT log-logistic	10.18	0.77	9.40	92.4%	x1.2

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]: A Single Technology Appraisal

Committee preference at ACM2

12 March 2026

Produced by	Peninsula Technology Assessment Group (PenTAG) University of Exeter Medical School
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1. COMMITTEE PREFERENCE AT ACM2

Table 1: Committee preferred assumptions at ACM2

Parameter	Value / Assumption
OS extrapolations	Chemo – SACT log-log; MIRV – MIRASOL HR
Health-state utility values	MIRASOL utilities (without treatment interaction effect)
Severity modifier	1.2
Vial sharing – mirvetuximab	10%
Relative dose intensity	Cycle-specific
Caregiver disutility	Not included
MIRV duration of treatment	Exponential only
Cost updates- ocular	Not included
Cost updates - administration	Included
AEs - management of anaemia and neutropenia	*12% inpatient, remainder day case
AEs - disutility for alopecia	Results requested with 0.12 and 0.05
Age (years)	67 (SACT)

*The EAG calculated inpatient costs as a weighted average of the costs for patients with a short hospital stay (less than two days) and those with a long hospital stay (two days or more), based on costs and activity levels reported in the NHS Cost Reference 2024

1.1. Revised EAG base case

The ICER has increased from the EAG SACT + HR scenario at the time of ACM1 ([redacted]) somewhat as we did not realise the company had hard coded in the 70% carer assumption in their response to the original EAG AC1 response by-passing the EAG switches. We have now fully removed carer disutilities which increased the ICER before applying the rest of the Committee assumptions. This offset the more favourable assumptions applied by the Committee around vial sharing, duration of treatment and AE management.

Table 2: Base case

Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER (£/QALY)	Change in ICER vs company base case	Abs SF	Prop SF	Severity modifier
Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		–	–	–
Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.403	92.4%	1.2

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Table 3: Additional scenario analysis

Scenario	Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER (£/QALY)	Change in ICER vs EAG base case	Abs SF	Prop SF	Severity modifier
Assuming disutility for alopecia 0.12	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.405	92.4%	1.2

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Notes: * Utility increase applied to mirvetuximab arm, independent effect of adverse events not included

1.2. Subgroups

Because the EAG does not have SACT data for the PPFI ≤6 months and PPFI >6 months subgroups, it cannot run subgroup scenarios using the committee's preferred assumption of incorporating real-world evidence. The EAG notes that, in MIRASOL, overall survival in the chemotherapy arm was longer than in the mirvetuximab arm for the PPFI ≤6 months subgroup, resulting in an ICER exceeding [redacted] in previous analyses. In this subgroup, the very small QALY gain for mirvetuximab was driven primarily by higher utility values rather than a survival benefit

In the analysis for ACM1, the PPFI >6 months subgroup the ICER was lower than that estimated for the ITT population [redacted] vs [redacted] Assuming a similar pattern would be seen when applying real-world evidence, the EAG would expect the ICER to increase substantially for the PPFI ≤6 months subgroup and to decrease slightly for the PPFI >6 months subgroup.

The EAG also reiterates that results from the MIRASOL trial for these subgroups should be interpreted with caution because the study was not powered to detect differences in these subgroups. Nevertheless, the direction of the results is consistent with clinical expectations, with outcomes appearing more favorable in the PPFI >6 months subgroup (HR lower than the ITT HR) and worse in the PPFI ≤6 months subgroup (HR closer to or >1).

Mirvetuximab soravtansine for treating folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer [ID6442]: A Single Technology Appraisal

Committee preference at ACM2; amended with SACT update

23 March 2026

Produced by	Peninsula Technology Assessment Group (PenTAG) University of Exeter Medical School
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The views expressed in this report are those of the authors and not necessarily those of the NIHR Evidence Synthesis Programme. Any errors are the responsibility of the authors.

1. COMMITTEE PREFERENCE AT ACM2

Table 1: Committee preferred assumptions at ACM2

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Relative dose intensity	Cycle-specific
Caregiver disutility	Not included
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Cost updates- ocular	Not included
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AEs - management of anaemia and neutropenia	*12% inpatient, remainder day case
AEs - disutility for alopecia	Results requested with 0.12 and 0.05
Age (years)	67 (SACT)

*The EAG calculated inpatient costs as a weighted average of the costs for patients with a short hospital stay (less than two days) and those with a long hospital stay (two days or more), based on costs and activity levels reported in the NHS Cost Reference 2024

2. COMMITTEE PREFERENCE AT ACM2

The EAG received an updated SACT data report in which the censoring approach was corrected to capture deaths occurring between April 2025 and October 2025. Following this, the log-logistic distribution remained the best fit model for OS, although parameter estimates changed slightly to reflect those additional events. The EAG explored the impact of this update in the economic model. The correction had a small effect on cost effectiveness, increasing the ICER by [redacted] from the previous base case.

Table 2: Previous base case

Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER (£/QALY)	Change in ICER vs company base case	Abs SF	Prop SF	Severity modifier
Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		–	–	–
Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.403	92.4%	1.2

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Table 3: Updated base case

Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER (£/QALY)	Change in ICER vs company base case	Abs SF	Prop SF	Severity modifier
Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		–	–	–
Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.429	92.7%	1.2

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Table 4: Additional scenario analysis

Scenario	Treatment	Total costs (£)	Total QALYs	Inc. costs (£)	Inc. QALYs	ICER (£/QALY)	Change in ICER vs updated EAG base case	Abs SF	Prop SF	Severity modifier
Assuming disutility for alopecia 0.12	Chemotherapy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	–	–	–
	Mirvetuximab	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9.429	92.7%	1.2

Abbreviations: AE, adverse event; EAG, external assessment group; ICER, incremental cost-effectiveness ratio; OS, overall survival; QALY, quality-adjusted life-year; RDI, relative dose intensity; SF shortfall

Notes: * Utility increase applied to mirvetuximab arm, independent effect of adverse events not included